Maternal and Child Health Services
Title V Block Grant

State Narrative for Colorado

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Appropriate Assurances and Certifications for non-construction programs, debarment and suspension, drug-free work place, lobbying, program fraud, and tobacco smoke, that are part of this grant, are maintained on file as required by the block grant guidance at the State's MCH administrative office on the fourth floor at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Colorado first placed online for review and public input its FY 2000 Maternal and Child Health Block Grant in 1999. Since that time, all narratives have been placed online. Users find online access to the grant very convenient, and comments throughout the year are solicited through a return email function on the Web site.

Much input was sought last year for the FY 2011 grant application through the intensive needs assessment process that was conducted. This process was described in detail in the needs assessment section (Section II).

A draft version of the FY 2011 grant application was placed on the state health department's Web site on July 1, 2010. The MCH Director sent a letter to key stakeholders informing them that comments were welcome. Appropriate changes were made in the final grant application before the July 15, 2010 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2011 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application.
An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The MCH Needs Assessment Steering Committee with the leadership of the MCH Director established the overall strategic direction and methodology for the needs assessment while providing the ongoing project management and oversight for the process. The process focused on identifying a set of specific priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based/ promising practices or interventions grounded in sound public health theory or research and consistent with the mission and scope of Colorado's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority. The process involved multiple state and community stakeholders/partners to enhance collaboration, and looked for opportunities to coordinate and integrate MCH efforts across the MCH continuum.

For purposes of assessment and strategic planning, the MCH population was defined as women, children, adolescents, children with special health care needs, and families. The MCH population was further subdivided into women of reproductive age (ages 15-44), early childhood (ages birth-8), including children with special health care needs and child/adolescent (ages 9-21), including children and youth with special health care needs.

The Needs Assessment Steering Committee employed a three-phase methodology in planning and implementing Colorado's needs assessment. During Phase I, staff devised two strategies to solicit both qualitative and quantitative data to identify potential MCH priority areas. The first strategy involved convening a group of ten subject matter experts for each MCH population who served as expert panelists charged with identifying potential focus areas for future MCH. Panelists were presented with a series of background documents to inform the process and the panels were guided by a set of expectations regarding data-based decision making, prioritization criteria and desired outcomes. Prioritization criteria included considering potential issues in terms of the MCH/public health role, the existence of strategies for intervention, and the ability to demonstrate outcomes/results within five years using specific indicators that could measure and demonstrate progress.

The second Phase I strategy involved creating an updated version of the Colorado MCH Health Status Report, which served as a means for compiling and analyzing quantitative MCH population data. The revised report used a life course perspective. At the end of the expert panel process, results were summarized from all three groups and presented to the Steering Committee, along with the preliminary draft of the Colorado MCH Health Status Report. Phase I, then, concluded with the identification of 21 potential MCH priorities, generated by the expert panels, spanning the three populations.

During Phase II, the potential priorities identified by the expert panels were presented to key stakeholders, via a survey. The survey was sent to 265 stakeholders with 172 completing the survey for a completion rate of 62 percent. Survey participants chose their top three issues for each population and also identified any important issues not reflected in the original twenty-one topics. However the majority of issues identified by survey participants had been discussed by the Expert Panels or other stakeholders in earlier phases of the needs assessment process. Local health agency directors were asked to assess the capacity of their agency to address the potential MCH priority areas.

Phase III included the final prioritization process and state capacity assessment to determine the MCH priorities for FY2011-2015, including identification of the state performance measures. MCH staff prepared a two-page justification for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue and specific indicators that could be used to measure success within the five-year period. These issue papers, along with the assessment of state capacity, served as key resources for discussion in determining the final set of nine priorities. This phase also included the identification of all work being currently completed under the auspices of the MCH program that needed to continue. Following these discussions, each issue was ranked and the final priority area were selected.

Several factors have affected MCH population needs in Colorado over the past five years. They include the ongoing strong growth in population numbers. Colorado, like the nation, is in a recession. This economic downturn has led to job loss, wage declines, and loss of wealth with different rates of recovery predicted for the state's geographically diverse industries. State governmental revenues have fallen; there will be an estimated fiscal year 2011-2012 budget shortfall of $838 million dollars. This situation puts a strain on Colorado residents and their ability to make ends meet and retain health insurance, increasing the need for governmental safety-net services. It has also affected the work of state government, as state workers were required to take several furlough days during FY10. However, these challenges have not significantly impacted the work of the MCH program. In 2010, a new governor will be elected, which will impact policies and direction for the state health department and thus the MCH program.

Over the last five years, Colorado has continued to move from direct and enabling to infrastructure and/or population-based services. There are more collaborative efforts with MCH taking the role of convening partners to participate in joint activities. Uses of MCH theory and practice have been enhanced.

III. State Overview

A. Overview

Introduction

This section discusses the Colorado's health care delivery environment. It also provides an overview of the factors impacting health services delivery such as: poverty, racial and ethnic disparities and geography. More detailed analysis of these factors and others are found in the needs assessment section. The needs assessment section also delineates how these factors were analyzed within the process that led to the identification of the nine Colorado MCH priority areas.

For the Colorado needs assessment and planning process, the state used a conceptual framework that integrated a strengths-based approach with the goal of optimizing health and well-being among the MCH population across the life course. The approach took into account that a complex interplay of biological, behavioral, psychological, and social factors (e.g., both risk and protective) contribute to health outcomes (e.g., the Life Course Health Development Model). In alignment with this model, the influence of early life events (early programming) and critical periods across the life course were considered with attention given to the cumulative impact of experiences over time, which resulted in an emphasis on primary prevention and early intervention. The social determinants of health were also considered as factors that shape the health of individuals and communities.

For purposes of assessment and strategic planning, the MCH population was defined as women, children, adolescents, children with special health care needs, and families. The MCH population was further subdivided into women of reproductive age (ages 15-44), early childhood (ages birth-8), including children with special health care needs and child/adolescent (ages 9-21), including children and youth with special health care needs.

The needs assessment process focused on identifying a set of specific priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based/ promising practices or interventions grounded in sound public health theory or research and consistent with the mission and scope of Colorado's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority.

In the beginning stages of the Colorado's needs assessment, two strategies were used to solicit both qualitative and quantitative data to identify potential MCH priority areas. The first strategy involved convening groups of subject matter experts. The second Phase I strategy involved creating an updated version of the Colorado MCH Health Status Report, which served as a means for compiling and analyzing quantitative MCH population data.

Geography

The Rocky Mountain state of Colorado is bounded on the east by Kansas and Nebraska, on the north by Nebraska and Wyoming, on the west by Utah and on the south by New Mexico and Oklahoma. Colorado is the eighth largest state when measured in square miles and consists of different regions of mountains, plateaus, canyons and plains. Generally, the eastern half of the state has flat, high plains and rolling prairies that gradually rise westward to the Front Range foothills and the higher ranges of the Rocky Mountains. Colorado has the highest mean elevation of any state with more than a thousand mountain peaks over 10,000 feet high including 54 that are over 14,000. The Continental Divide runs from north to south through west central Colorado and bisects the state into the eastern and western slopes.

The state can be divided into five distinctive regions within its 64 counties: the Front Range, the Western Slope, the Eastern Plains, the Central Mountains, and the San Luis Valley. Each of these areas grew in population between 2000 and 2007, ranging from a 3 percent increase in the

Eastern Plains to an 18 percent increase on the Western Slope. Close to 85 percent of the population lives in urbanized areas and 82 percent of the population lives in the Front Range, which includes the metropolitan areas of Denver-Boulder, Ft. Collins, Greeley, Colorado Springs, and Pueblo. The San Luis Valley in the southern part of the state is the region with the smallest population, with about 48,000 residents. The rural vastness of much of the state is confirmed by 20 of Colorado's 64 counties which qualify as frontier counties containing fewer than 6 persons per square mile; of these 20, eleven have 2 or fewer persons per square mile.

Population

Colorado, ranking 22nd among states based on the size of its population, has had one of the fastest growth rates of all states. The overall population for Colorado in 2010 is projected to reach over 5 million--5,218,146; this projection is an increase of over 10 percent since 2005, when the estimated Colorado population was 4,731,787 residents. By 2015, the population is projected to increase by another 10 percent, reaching 5,737,307.

Population growth is determined by the number of resident births, deaths, and migration into the state. The ratio of births to deaths has consistently averaged over twice as many births as deaths in a given year. Between 2000 and 2008, the number of Colorado births increased by just 7 percent, reducing the very rapid growth in the total number of births that had been seen in the decade of the 1990s. In 2000 there were 65,000 births; the number of births has risen since then but remained at approximately 70,000 annually between 2006 and 2008. Preliminary estimates for 2009 actually suggest a decline to about 68,600. A drop this substantial can be attributed in large part to the downturn in the economy.

Women between the ages of 25 and 34 consistently contribute over 50 percent of births each year; in addition, women in this age group have not shown any decline in fertility rates in the past decade in contrast to the experience of younger women. Thus, the expected growth of women who are age 25 to 34 in the coming years will have a significant impact on the need for maternal and infant services and supports.

While the number of deaths annually has risen, both the crude and adjusted death rates have fallen since 2000. It is important to note as well that migration has been an important factor in the state's population growth in recent years. Between 2000 and 2008 net migration (the total number of people moving to the state minus the number leaving) exceeded 433,000 people. Between 2009 and 2012, net migration is expected to account for over 50 percent of the increase in total population, with an additional 143,000 residents arriving.

The two major racial and ethnic groups in Colorado are composed of White non-Hispanic persons and persons of any race who are of Hispanic origin or ethnicity. Estimates from the American Community Survey (2008) of the U.S. Census Bureau show that 70.9 percent of Coloradans identify themselves as White non-Hispanic and 20.2 percent identify themselves as of Hispanic origin. Non-Hispanic groups include African-American/Black (3.6 percent), Asian and Pacific Islander (2.6 percent), American Indian (0.6 percent) and people who report other races or more than one race (2.2 percent).

The Hispanic population has grown rapidly in recent years; from 735,601 in 2000 to an estimated 963,831 in 2006-2008 according to the most recent three-year estimates available from the American Community Survey. The vast majority of the Hispanic population is of Mexican descent, while virtually all the rest is from Central and South America. Over 71 percent of the Hispanic population in Colorado was born in the United States; 29 percent was not. Almost 16 percent of those born outside the U.S. are naturalized citizens.

Approximately 17 percent of Colorado residents age 5 and older speak a language other than English at home; over 70 percent of those speaking another language in the home speak Spanish. Four percent of households in Colorado are estimated to be linguistically isolated, i.e., all members 14 years and older have at least some difficulty with English.

Education

Colorado has an educated population. Over one-third (34.6 percent) of all Coloradans age 25 and older have a college degree or more and Colorado is ranked 4th among all states and the District of Columbia in the percentage of the population with a college degree. Educational attainment varies by race and ethnicity in Colorado; 46 percent of Asian/Pacific Islanders have a college degree or more as do 40 percent of White, non-Hispanics, 22 percent of African Americans/Blacks, and 11 percent of Hispanics. The high rate of college graduates in the state is reflected in the work force in Colorado; Colorado's economy has been based on employment in the service-based industries for more than six decades. The service-based industries cover a wide range of businesses that do not produce tangible goods and include professional, scientific, technical, managerial, administrative, educational, health care and social assistance, and accommodation and food services.

Income and education are highly correlated. Eighty-one percent of all low-income children come from families where parents had less than a high school education. The poverty rate for Coloradans age 25 and older who do not have a high school diploma is 23 percent compared to just over 3 percent for those with a college degree or higher.

While the prevalence of college graduates in Colorado is high, the percentage of high school students who graduate is relatively low. This state of affairs exists because many highly educated people migrate to Colorado after completing their education; they have completed at least high school elsewhere. High school graduation rates for Colorado for 2006, 2007, and 2008 show only three-fourths of Colorado's students who started 9th grade are known to have graduated from high school within four years. A Healthy People 2010 objective is to increase high school completion to 90 percent, and Colorado's students fall far short of the target.

Disparities in graduation rates also mimic the disparities in college graduation attainment among adult Coloradans, with Hispanics having the lowest high school graduation rate and Asian-Americans having the highest. Other groups that are consistently at risk of not graduating from high school include homeless children and children who are not proficient in English. From 2006 through 2008, graduation rates have increased slightly for Black students but have fallen for students with disabilities, those with limited English proficiency, homeless students, and those who are economically disadvantaged.

Students who do not graduate from high school are the most likely to experience low incomes and face the health-related consequences associated with lower incomes.

Economy

The downturn in the national economy since the end of 2007 has dramatically affected Colorado, resulting in the state's worst downturn in 50 years. As of July, 2009, unemployment stood at 7.8 percent, doubling since 2007 when the unemployment rate was at its lowest (3.8 percent). During the first half of 2009, there was a net loss of over 74,000 jobs in Colorado, bringing the total number of jobs in the state to the same number there were in 2001. Job losses have not been focused on one particular sector of the economy but have been broad-based. Only two sectors showed some job growth in 2009: government and educational and health services. All other sectors of the Colorado economy lost jobs. The Colorado Legislative Council suggests that the economy in Colorado will begin to recover in 2010 but predicts a "snail-paced recovery."

Even with the increase in unemployment rates, Colorado and other western states have some of the lowest unemployment rates in the country. Colorado was ranked 18th lowest among all 50 states; but all states bordering Colorado have even lower unemployment rates. With the economy in a downturn, state revenues have also been falling. Staff from the state legislature estimate that by fiscal year 2011-2012 the budget shortfall for the state will reach $838 million dollars, putting pressures on all state-funded health programs.

The National Center for Children in Poverty estimated that in 2007, 32 percent of Colorado's children lived in low-income families whose income was less than 200 percent of the federal poverty level. Findings from the American Community Survey estimate that 15.3 percent of children lived in families whose income was at or below 100 percent of federal poverty level during this same time period. It is important to note that the rate of children living in low-income families is not evenly distributed throughout the population. Racial and ethnic minorities have much higher rates of children who live in low-income families than the majority population (White, 19 percent; African American/Black, 60 percent; and Hispanic/Latino, 56 percent). Rural (54 percent in 2006) and urban children (45 percent, 2007) are more likely to live in low-income families than suburban children (22 percent, 2007). The majority of children living in low-income families live in families where the parents are married (60 percent) and have at least one parent who has full-time year-round employment (65 percent) indicating that many of these families are having trouble meeting expenses because they are working in low-wage jobs.

The above data on income were reported for periods prior to the economic downturn. The Bureau of Economic Analysis found that personal income in Colorado declined by 1 percent in the 4th quarter of 2008 and another 0.7 percent in the first three months of 2009. Thus, it is important to remember that the data that are available on income most likely underestimate the number of women and children living in poverty and in low-income families in Colorado at this time.

Access to Health Care
Approximately 81 percent of Coloradans under the age of 65 have health insurance of some kind; over 86 percent of those under 19 have health insurance. These percentages are low, however, compared to other states. Colorado is ranked 36th among all states and the District of Columbia based on the percent of persons younger than 65 years old who have health insurance coverage, 43rd for those under age 19, and 49th for those under age 19 and below 200 percent of the federal poverty guideline.

The highest rate of coverage is for White non-Hispanics with over 87 percent reporting that they have health insurance. By contrast, less than half of all Hispanics younger than age of 65 with incomes below 200% of the federal poverty designation have health insurance. It is unknown how many of those who are insured are underinsured because deductibles and co-payments act as barriers to receiving care.

Several programs are available to reach low-income families and those without health insurance. Pregnant women and children living in households at or below 205 percent of the federal poverty level are eligible for health insurance coverage either through Child Health Plan Plus (CHP+) or Medicaid. Enrollments in these two programs have increased, and 543,000 Colorado children are now covered. A total of 7 percent of all Colorado children were enrolled in CHP+ at some time between July 2008 and June 2009, and 32 percent of all Colorado children were enrolled in Medicaid in the same period. Other health care services available to low-income and uninsured persons include 15 community health centers that operate 138 clinic sites in 35 counties. These are non-profit or public health centers where 90 percent of their patients have incomes below 200 percent of the federal poverty level and 40 percent are uninsured by either public or private programs.

B. Agency Capacity

The following section describes each of the three primary units within the MCH Program that address pregnant women, mothers, infants, children and youth, including children and youth with special needs. Information about state support of communities, coordination with health components of community-based systems; and coordination of health services with other services at the community level is provided by unit. Responses to the questions about the CSHCN Unit's ability to provide and promote family-centered, community-based, coordinated

care including care coordination services for CSHCN and facilitate the development of community based systems of services for such children and their families is integrated into the segment describing the CSHCN activities.

1. Services to pregnant women, mothers and infants
The Women's Health Unit (WHU) promotes health and wellness by promoting health and well-being, education and support for women and men of reproductive age in Colorado. The unit administers programs that promote lifestyles and behaviors that improve health status and emphasize the value of preconception health and family planning as public health priorities. The WHU provides funding, oversight, direction, consultation, training and technical assistance to state and local public and private entities serving women and families. The unit also participates in program development and systems building efforts at the state and local levels and in analysis of federal, state and local policies impacting these populations. The WHU administers the Prenatal Plus, Nurse Home Visitor, Title X Family Planning Programs and the Colorado Family Planning Initiative. Under Maternal Child Health (MCH), the WHU oversees the Healthy Baby Campaign.

The WHU administers the Prenatal Plus Program on behalf of the Colorado Department of Health Care Policy and Financing (HCPF). Prenatal Plus is a Medicaid-funded program that provides care coordination, nutrition and mental health counseling to eligible pregnant women who are at a higher risk for delivering low birthweight infants. The program's multidisciplinary approach uses professionals to effectively address risk reduction for women enrolled in the program. Care coordinators address client needs throughout pregnancy and up to 60 days postpartum. Concerns addressed include housing, nutrition, employment, domestic violence, substance abuse, high life stress, and depression and/or other mental health problems that may increase the risk of delivering a low birthweight infant. The Prenatal Plus Program served approximately 1,900 women covering 21 counties through 34 sites comprised of local health agencies, community health centers, private non-profit organizations, and hospital-based clinics. This program will be administered by HCPF as of June 2011, given that administration of Medicaid benefits is the agency's primary mission. The MCH Program is focused on population-based and infrastructure-building activities.

The Nurse Home Visitor Program funds the Nurse-Family Partnership (NFP) model, which is an evidence-based, community health program that helps improve the lives of low-income mothers pregnant with their first child. An NFP mother is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits (64 planned visits) that continue through her child's second birthday. Through ongoing home visits, mothers receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. The program disseminates nearly $13 million in master tobacco settlement funds annually to 19 local public health and non-profits agencies for nurse home visitation services covering 53 of the states' 64 counties, approximately 2,590 mothers are served annually.

Nurse Home Visitor Program staff collaborate with HCPF to draw down federal Medicaid funding for Targeted Case Management (TCM) services provided to first-time, low-income (up to 200 percent of the Federal Poverty Level) mothers. The Nurse Home Visitor Program contributes the match for Medicaid reimbursements paid directly to the providers. Medicaid reimbursements support program expansion by generating additional program revenue, which is used to serve more families. Recent rate adjustments have resulted in a significant drop in reimbursement for NHVP TCM.

Title X Family Planning distributes about $4.7 million to 29 local public health and non-profit agencies in 38 counties to provide family planning services to about 62,000 men and women. Title X Family Planning staff work closely with HCPF and the Centers for Medicare and Medicaid Services (CMS) in a long standing attempt to gain approval for a Reproductive Health 1115 Medicaid Waiver for family planning services. The waiver is intended to expand family planning

services to men and women 19-50 years old with incomes up to 200 percent of the Federal Poverty Level. As a result of the federal health care reform, states now have the option to create a family planning-only benefit under a state plan amendment.
The Title X Family Planning, Colorado Family Planning Initiative and Nurse Home Visitor Program funding is distributed among the network of local health departments, community health centers, hospitals and non-profit agencies to best support and build existing community infrastructure and to fund needed services in local communities. The Prenatal Plus program is administered throughout the state in coordination with this same local health network.

Per statute, the WHU staff cooperates with the University of Colorado Cord Blood Bank to transfer voluntary state income tax check-off funds from the state health department to the University for the Adult Stem Cells Cure Fund. The funds are used to increase public awareness and to encourage umbilical cord blood donations to public blood banks to aid in the cure of life-threatening diseases.

WHU personnel serves on a number of teams, including private organizations and other public agencies, related to the unit's mission. These groups include the Adolescent Sexual Health Team, Advisory Council on Adolescent Health, Colorado Clinical Guidelines Collaborative, Colorado Nurse-Family Partnership Coordination Team, Perinatal Care Council, Folic Acid Task Force, Healthy Women/Healthy Babies, Infertility Prevention Project Regional Advisory Committee, March of Dimes State Programs Committee, Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid, Sexual Risk Prevention Group, Cessation Resource Alliance, Covering Kids and Families Workgroup, Maternal Mortality Review Committee, Prevention First NARAL Education Committee and the U.S. Department of Health and Human Services/ Office of Public Health and Science/ Women's Health/ Region VIII Partners.

The WHU supports local communities through a variety of means, including state, federal and private funding, training and technical assistance. The MCH generalists and specialists work with 15 local county public health agencies on their MCH plans, which include preconception and prenatal goals. The MCH generalist within the WHU provides consultation and assistance to local health departments with their needs assessment and preparation of their three-year MCH plans for all three core MCH populations.

The Healthy Baby Campaign provides support and resources to local communities related to low birth weight and inadequate weight gain through technical assistance, the campaign website and continued dissemination of campaign materials, including brochures, weight grids and BMI wheels.

The Colorado Family Planning Initiative, funded by an anonymous donor, distributes $4.8 million to 29 local public health and non-profit agencies in 38 counties to help expand family planning services to men and women.

MCH staff worked with the Colorado Clinical Guidelines Collaborative and the HealthyWomen HealthyBabies Preconception Care Workgroup to develop a Preconception and Interconception Clinical Care Guideline. The guideline was completed in December 2009 and disseminated to nearly 4,500 health care providers around the state.

A Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid were developed with the State Tobacco Education and Prevention Partnership to address the high rates of tobacco use among these populations. The group's goal is to increase use of the Colorado QuitLine service and Medicaid's tobacco cessation benefit. The staff also worked with the QuitLine to enhance the protocol to more effectively target pregnant and postpartum women.

WHU personnel also participates in a number of groups related to community-based health systems, including Medical Policy Advisory Committee, Policy Advisory Committee and the

Medicaid Waiver Advisory Committee for the Title X Family Planning program, Prenatal Plus Advisory Committee and the MCH Coordinating Team.

2. Preventive and Primary Care Services for Children
The Child, Adolescent, and School Health (CASH) Unit leads efforts to improve the health and well-being of all Colorado children and adolescents through health promotion, public health prevention programs and access to health care. The unit provides leadership in setting priorities; identifying and promoting best practices to address the priorities; and working with local public health agencies, early childhood councils, schools and other state and community partners to develop and implement comprehensive, coordinated strategies to improve the health of children and adolescents.

The organizational structure of the unit includes three teams: an early childhood team; an adolescent and school health team; and the Tony Grampsas Youth Services team. Across these three teams, a variety of state- and federally-funded programs and initiatives to address the needs of children, youth and families are administered.

The Early Childhood Team is currently focused on the following programs/initiatives: the Early Childhood Comprehensive Systems Grant, the Early Childhood Health Integration Initiative, the Assuring Better Child Health and Development Project, and the Early Childhood Obesity Prevention Needs Assessment Project.

The Early Childhood Systems (ECCS) Grant supports a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age eight and their families. The Early Childhood Colorado Framework and the Framework in Action State Plan were developed to guide the state's systems-building efforts. Colorado's Lieutenant Governor has identified early childhood issues as a top priority and the ECCS Director, a CDPHE employee, is now physically located within the Office of the Lieutenant Governor.

The CASH Unit receives funding from a local foundation to provide technical assistance to those local early childhood councils receiving Early Childhood Health Integration grants. The technical assistance supports the integration of health into local early childhood systems-building efforts. A staff person was hired to assist the local councils in the development and implementation of local health integration plans.

The CASH and Health Care Program for Children with Special Health Care Needs Units work together to implement the Assuring Better Child Health and Development Project that focuses on: promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns; and strengthening the referral and service-delivery processes for early intervention.

In partnership with the Nutrition Services Branch (WIC and CACFP) and the Colorado Physical Activity and Nutrition Program, the CASH Unit has coordinated an early childhood obesity prevention needs assessment project. The results of the needs assessment will be used to inform a statewide strategic plan to address early childhood obesity, with a focus on prenatal through age two.

The Adolescent and School Health Team within the Unit, is focused on the School-Based Health Center Program, the Coordinated School Health Program, school health technical assistance, and youth sexual health initiatives.

The School-Based Health Center Program, in collaboration with the Colorado Association for School-Based Health Care, convenes, facilitates, and provides technical assistance to schools and provider agencies that develop, implements, and supports approximately forty school-based health centers throughout the state. The School-Based Health Center Program, located within the CASH Unit, receives one million dollars in state general fund dollars to support school-based

health centers throughout Colorado. In addition, the Colorado Department of Health Care Policy and Financing, in collaboration with CDPHE, has received a five-year evaluation grant for school-based health centers in Colorado funded through the Child Health Insurance Program Reauthorization Act. In order to meet the grant deliverables, the CASH Unit will be hiring one additional full-time staff person.
Colorado is in the second year of a five-year funding cycle for the Coordinated School Health Program from the Centers for Disease Control and Prevention. The funding supports a partnership between the Colorado Department of Education and CDPHE to build state and local infrastructure to support the coordinated school health model, with an emphasis on nutrition, physical activity and tobacco prevention. In addition to CDC funding, the Coordinated School Health Program receives funding from a local foundation to support school health teams throughout Colorado to address the program's priorities.

One of the three MCH Generalist Consultants is located within the CASH Unit, and has expertise in school nursing. As part of this role, the consultant collaborates with the Colorado Department of Education's statewide nurse consultant to prove technical assistance and training for school nurses.

The CASH Unit is providing leadership for a collaborative effort to address youth sexual health. The Unit is partnering with the Women's Health Unit, the STI/HIV Program, Colorado Youth Matter (formerly, the Colorado Organization on Adolescent Parenting, Pregnancy, and Prevention), Pregnancy, and Prevention, and the Department of Education to create a statewide youth sexual health strategic plan.

The third team within the CASH Unit implements is the Tony Grampsas Youth Services Program is focused on the prevention of youth crime and violence, as well as reducing child abuse and neglect. The Tony Grampsas Youth Services Program, funded with master settlement tobacco funds, supports over 90 contracts with local non-profit organizations throughout the state to prevent youth crime and violence, as well as child abuse and neglect. These funds support early childhood programs, student drop-out prevention programs, youth mentoring, restorative justice, after-school programs, as well as a variety of other programs targeting high-risk youth and families.

Advisory groups convened by the CASH Unit include the Early Childhood Partners, the Interagency School Health Team, the Advisory Council on Adolescent Health, the Colorado Youth Development Team, the Youth Partnership for Health and the Tony Grampsas Youth Services Board. The Early Childhood Partners is a multi-disciplinary group of public and private early childhood stakeholders who advised in the creation, and now implementation, of the Early Childhood Colorado Framework in Action State Plan. The Interagency School Health Team serves as the advisory group for the Coordinated School Health Program. The Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and community advocates, who advise the Colorado Department of Public Health and Environment, educate and inform the public, and advocate for policies and programs to improve the health and well-being of all Colorado adolescents. The Colorado Youth Development Team is a public-private partnership of youth and professionals that raises awareness, promotes, enhances and unites positive youth development efforts and strategies across the State of Colorado. The Youth Partnership for Health is composed of 25 diverse youth, recruited from all parts of the state. YPH advises the state health department on policies and programs that affect adolescents. The Tony Grampsas Youth Services Board is an 11-member that provides guidance and oversight for the TGYS Program. Appointments to the board are made by the Governor, the Speaker of the House of Representatives, the Senate President, and the Senate Minority Leader.

Collectively, these advisory groups include representatives from the Department of Human Services (Divisions of Behavioral Health Services, Child Care, Youth Services, Child Welfare, and the Office of Homeless Youth); the Department of Transportation; the Department of Education (Coordinated School Health Program, School Nursing Services, Special Education Services,

Early Childhood Initiatives); the Department of Public Safety; the Colorado State University Cooperative Extension Program; higher education; Colorado-based foundations and other many other public and private partners.

3. Services for Children with Special Health Care Needs (CSHCN)
The Children with Special Health Care Needs Unit includes the Health Care Program for Children with Special Needs (HCP), the Newborn Screening Programs, the Family Leadership Initiative and The Colorado Medical Home Initiative (CMHI).

The unit's purpose is to build a sustainable system of care for CSHCN and their families in alignment with the six CSHCN national outcome measures. To champion a medical home approach for families, the HCP Program has chosen two core strategies; these are care coordination and local systems building. It is expected that successful implementation of these strategies will decrease systems barriers to care and reduce unmet needs among families.

All programs/initiatives in the CSHCN Unit collaborate with other state agencies and private organizations for children with special health care needs.

A statewide clinic system exists for children with special health care needs resulting from the coordination of local and state resources. The HCP program provides gap filling care coordination services and strives to avoid duplication and to compliment other similar services in the state. The HCP state program contracts with 15 counties to serve as regional offices to provide administration and implementation of the program statewide. Program planning and reporting processes are implemented with state staff support and consultation. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in ensuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

HCP has developed a care coordination definition describing three levels of coordination, service standards and an evaluation process. The care coordination definition and standards are used with Medicaid EPSDT outreach, Early Intervention Colorado, children receiving clinic services, the Colorado Responds to Children with Special Needs birth defects registry, and for infant hearing screening follow-up.

Public health nurses and HCP's regional office teams work together so that there is coordination at the local level among the services needed by families and children. All local HCP agencies provide resource and referral information. Each HCP agency provides care coordination services to targeted populations depending on community need, capacity, and reimbursement. Additionally, local systems building services are provided in every county. Most local HCP staff are also involved in other interagency work such as serving on child protection teams, working with school districts to support parents in special education staffing, and developing Individual Education Plans or Individual Family Service Plans.

HCP also provides access to specialty services and coordination of primary and specialty care by providing clinics in outlying and rural communities. Last year there were 2,428 community encounters by public health contractors with other providers, agencies and organizations to organize services for ease of use by families. Access to specialty medical providers was addressed through 99 Specialty Clinics (Orthopedic 8, Neurology 64, Cardiology 5, Rehabilitation 18, and Pediatric 4). There were 1,116 total completed patient visits offered through 14 specialty clinic sites in 13 counties.

Through the state health department's laboratory, the Newborn Screening Program provides screening at birth and again at eight to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the state. The program provides data to ensure appropriate follow-up with contract sites. The Newborn Hearing Screening Program connects hospital birth certificate clerks and hospital audiologists with local HCP and early intervention personnel to

ensure follow-up screening and referral into early intervention. The metabolic screening program connects families with The Children's Hospital and community-based services. The program contracts with The Children's Hospital for follow-up services and makes connections to community supports to develop a medical home approach for children with metabolic conditions.

The Colorado Infant Hearing Program tests the hearing of infants at birth to identify deaf and hearing impaired infants and makes appropriate referrals. The Newborn Hearing Screening Program provides support to local communities that have low follow-up rates, by developing Early Hearing Detection and Intervention (EHDI) teams to develop systems for follow-up and referral into early intervention. The Colorado Infant Hearing and Newborn Screening Advisories address standard practices, funding, and program development. The committee is comprised of parents, consumers, public health professionals, physicians, and other stakeholder state agencies.

The Colorado Infant Hearing Program has a CDC Early Hearing Detection and Intervention (EHDI) grant that is used to integrate several data systems: the newborn hearing; newborn metabolic screening; the Colorado Responds to Children with Special Needs birth defects registry data, metabolic clinics at The Children's Hospital, and the Traumatic Brain Injury Program.

Colorado Responds to Children with Special Needs (CRCSN) is the state's birth defects monitoring and prevention program. CRCSN and HCP share data so that HCP can link children and families, who have been identified with birth defects and related disabilities, with early intervention services and potentially care coordination.

The CSHCN Unit's Family Leadership Initiative partners with the Department of Education and the Department of Human Services, early childhood efforts, the state Prevention Leadership Council of six state departments, as well as non-profit organizations to advise the development of family engagement and leadership in the state. These partners promote the importance of family engagement and leadership and help to identify funding sources for local implementation of the Family Leadership Training Institute. The CSHCN Unit Family Leadership Initiative supports communities to implement the Family Leadership Training Institute (FLTI), an eleven week course to teach civic leadership and to support community projects for families and children.

The Colorado Medical Home Initiative (CMHI) is a state systems building initiative to improve the quality of the pediatric health care system to ensure a comprehensive, coordinated medical home team approach for all families. The CMHI partners with the Medicaid agency to implement Colorado's Medical Home legislation and to build the infrastructure to support a medical home system. The initiative partners with a broad array of stakeholders to build a system to support a medical home approach for all children. The Department of Health Care Policy and Financing, the Medicaid and SCHIP agency, partners with the CMHI to provide the clinical practice and quality improvement to ensure a medical home approach. The CMHI convenes partners to address state systems development, including the role of public health and families/consumers.

The CMHI Advisory Board provides updates and networking for over 50 agencies, organizations and individuals on a bi-monthly basis. The CMHI also provides information about the state's medical home efforts that connect and build infrastructure for an improved system. CMHI provides tools such as a medical home website and collects information about local projects.

The Integrated Services for Children with Special Health Care Needs implementation grant supports a project that is taking action to overcoming local systems barriers to a medical home approach in four counties (Boulder, Summit, Larimer and Mesa).

The Colorado Department of Human Services contracts with the HCP Program to provide care coordination through local offices to families of children with traumatic brain injury. Local HCP staff work closely with early intervention coordinators to assure that health-related early intervention services are coordinated.

The HCP program also works closely with Early Intervention Colorado at the Department of Human Services, Division of Developmental Disabilities to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs at the community level. An HCP staff member represents the program and the department on the Interagency Coordinating Council and the state level Memorandum of Understanding committee.

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. HCP personnel at the local community level provide care coordination when families have more complex medical or psychosocial needs.

Other Programs Supported by MCH funds
Child and maternal mortality reviews are done by a multi-disciplinary team working together to determine the underlying causes of maternal and child deaths. The reviews also promote preventive programs that may help reduce premature death. Multiple agencies and department programs are involved in both reviews.

The Family Healthline is the statewide MCH information and referral service. The Healthline resource specialist assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, or mental health. The Healthline specialists speak fluent Spanish and English.

Culturally competent care is provided to the State‘s MCH populations. The state health department has an Office of Health Disparities and a Citizen's Commission on Minority health. The office is dedicated to eliminating racial and ethnic health disparities in Colorado by fostering systems change and capacity building through multi-sector collaboration, so that all Coloradans will have equal opportunity to be healthy, regardless of race and ethnicity.

The Minority Health Advisory Commission was created in 2005 and established in statute in 2007. The commission provides a formal mechanism for community members to provide input on health programming at the level of the Colorado Department of Public Health and Environment Executive Director. It also helps the department determine culturally innovative data collection strategies and strengthens collaborations between the Colorado Department of Public Health and Environment and communities of color.

The Prevention Services Division, where the MCH Program is housed, has developed a Cultural Competence Plan based upon a division-wide assessment. Additionally, all staff received training this year on the Social Determinants of Health and will receive additional training on cultural competence in the coming year. All division personnel are required to participate in cultural competency training as part of their annual performance plan and all divisions units will implement activities that support the plan.

In 2009, the Child, Adolescent and School Health Unit coordinated a learning circle series, entitled, the Dimensions of Diversity. Part I included an overview of the social determinants of health framework, and a presentation of data that demonstrates how health disparities are a result of the social determinants of health. Part II focused on strategies for working in multi-cultural settings and was facilitated by the CDPHE Office of Health Disparities. The unit is continuing to participate in monthly learning circles. In December 2010, the unit will create a photo essay project that captures observations and insights.

Staff from both the CASH and Women's Health Units also viewed and discussed the Unnatural Causes six-segment documentary, produced by PBS, which illuminates the root causes of the socio-economic and racial inequities in health.

In 2009, the Women's Health Unit created the Health Equity Learning Community. The goal of this learning community is to address health equity and disparities through staff learning and practical application of data, information and experiences. The learning community objectives are all related to improving staffs knowledge of health disparities, health equity and cultural competency. In December 2010, the unit will create a photo essay project that captures community-based observations and insights related to the social determinants of health.

The CSHCN Unit held a conference about cultural competency in October 2008 that featured Wendy Jones from the National Center for Cultural Competence with follow-up meeting scheduled in 2009.

Data collected, analyzed and used through the MCH program is available by gender, race and ethnicity so information about culture does inform program development and service delivery.

C. Organizational Structure

The Colorado Department of Public Health and Environment is one of sixteen Colorado state agencies that are all located in Denver. Martha Rudolph is the Executive Director, and reports to Governor Bill W. Ritter, Jr. A CDPHE organization chart is posted at http://10.1.0.61/ic/orgchart.pdf.

The MCH program is located within the Prevention Services Division (PSD) which has two centers: the Center for Healthy Families and Communities and the Center for Healthy Living and Chronic Disease Prevention, along with an Office of Policy, Fiscal Analysis and Operations. A cross-divisional Epidemiology, Planning and Evaluation Unit was developed about three years ago which provides all of the epidemiology and evaluation services for all programs within the PSD, including MCH. Jillian Jacobellis, PhD directs the division.

The Center for Healthy Families and Communities houses all MCH activities and is directed by Karen Trierweiler, MS, CNM who is also the state MCH Director. The Center for Healthy Families and Communities includes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); the Child and Adult Care Food Program housed with WIC; the Women's Health Unit (Family Planning, Prenatal, Prenatal Plus and Nurse Home Visitor Programs); the Child, Adolescent & School Health Unit (Early Childhood Initiatives, Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and the Tony Grampsas Youth Services Program); the Children with Special Health Care Needs Unit; the Injury, Suicide and Violence Prevention Unit; and the Center's Fiscal and Administrative Services Unit.

The Center for Healthy Living and Chronic Disease Prevention includes the Chronic Disease Prevention Branch (Diabetes; Cardiovascular Disease; Comprehensive Cancer Program; Breast & Cervical Cancer Program; and the Oral Health Unit; the Healthy Living Branch that includes the Healthy Aging Unit, State Tobacco Education and Prevention Partnership, Colorado Obesity, Physical Activity and Nutrition Unit; and a Center-specific Fiscal and Administrative Services Unit. The Center has recently been reorganized according to function as opposed to program.

The Office of Policy, Fiscal Analysis and Operations includes the Interagency Prevention Systems for Children and Youth, which contains the Inter-Departmental Prevention Leadership Council; the Primary Care Office; and provides coordination of the Division's overall fiscal policy and human resources functions.

The Epidemiology, Planning, and Evaluation (EPE) Branch works collaboratively with programs in the Prevention Services Division and other partners to conduct systematic collection, analysis and interpretation of population-based and program specific health and related data in order to

assess the distribution and determinants of the health status and needs of the population, for the purpose of planning and implementing effective interventions, promoting policy development, and evaluating the outcome of these activities.

MCH funds are distributed to local contractors (primarily local health agencies) via a formal planning process. Based on the state-defined MCH priorities, contractors are asked to assess and prioritize the local health status needs of the prenatal, child and adolescent, and children with special health care needs populations and to identify how their allocated MCH funds will be used. The services or activities they implement are expected to address the Colorado MCH priority areas. The state-level MCH program assists agencies by providing consultation and technical assistance in developing and carrying out plans and managing statewide initiatives and efforts. More information about the MCH planning process and forms are at www.mchcolorado.org.

D. Other MCH Capacity

Title V funds and matching state funds support 31.50 FTE exclusively housed at the Colorado Department of Public Health and Environment in Denver.

The Maternal and Child Health Program is directed by Karen Trierweiler, MS, CNM. It is comprised of four units. A Fiscal and Contracts Management Section is led by Laurie Freedle. The Director of the Women's Health Unit is Esperanza Ybarra; Rachel Hutson RN, MS, serves as the Director of the Child, Adolescent, and School Health Unit; and Kathy Watters, MA, directs the Children with Special Health Care Needs Unit. The SSDI Coordinator is Helene Kent. Organizational charts for the Center for Health Families & Communities is attached.

There is one paid FTE family consultant within the Health Care Program for Children with Special Health Care Needs at the state health department in Denver. Each of the regional offices associated with the program has a family consultant.

Brief Biographical Information for Key MCH Management Staff
Karen Trierweiler, CNM, MS is the Director of the Center for Healthy Families and Communities and the state MCH Director. Ms. Trierweiler is a certified nurse midwife with over 30 years of experience in women's health as a clinician, educator, and public health professional. She received both her undergraduate and Master's degrees in Nursing from the University of Colorado. Ms. Trierweiler has worked at the Colorado Department of Public Health and Environment since 1990, originally as a nurse consultant, and formerly served as the Director of the Women's Health Section and Title X program director.

Laurie Freedle, BS has been the Director of the Fiscal Services Unit for the Center for Healthy Families and Communities since 2008. Her Unit administers all aspects of fiscal management for Maternal Child Health Block Grant, Women's Health Unit, Injury, Suicide and Violence Prevention Unit, Children with Special Health Care Needs Unit, and Child, Adolescent School Health Unit. Previously, Ms. Freedle was with the Colorado Department of Transportation for eleven years. She was the finance director and managed over $1 billion in state, federal, and local government funding, as well as a $1.3 billion bonding program.

Gina Febbraro, MPH is the Maternal and Child Health (MCH) Program Manager. Prior to joining MCH, Gina managed a variety of MCH-related programs including the Tony Grampsas Youth Services Program at the CDPHE and a sexuality education and teen pregnancy prevention program at Girls Incorporated of Metro Denver. Gina received her Master's in Public Health from the University of North Carolina, Chapel Hill and her Bachelor's degree from the Pennsylvania State University.

Kathy Watters, MA is the Director of the Children with Special Health Care Needs Unit Kathy Watters came to the Colorado Department of Public Health in 1984 from the Colorado

Department of Education's State School for the Deaf and Blind. She received her undergraduate degree in Communication Disorders from the University of Cincinnati and her Master's degree in Audiology from the University of Colorado-Boulder. Kathy began her career at the state health department as the Home Intervention Program Director. She subsequently became the Hearing and Speech Director, the Consultation Team Director, the HCP Assistant Director, and the HCP Director. She is now the Unit Director for Children with Special Health Care Needs.

Rachel Hutson RN, MS is the Director of the Child, Adolescent and School Health Unit. Ms. Hutson has been with the Colorado Department of Public Health and Environment since 2001, as the Director of Early Childhood Initiatives. She now provides supervision and oversight for Early childhood Systems Development, the Coordinated School Health Program, the School-Based Health Center Program, Adolescent Health Program, and the Tony Grampsas Youth Services Program. Prior to working for the department she was the Pediatric Health Services Coordinator at the Colorado Coalition for the Homeless, where she provided primary health care services as a Pediatric Nurse Practitioner at the Stout Street Clinic in Denver. Ms. Hutson received a BA from Franklin and Marshall College and a Masters in Nursing from Yale University.

Esperanza Ybarra, BSW, MAOM is the Director of the Women's Health Unit. Ms.Ybarra assumed the director position this year. She directed the Nurse Home Visitor Program for over six years and worked with the Women's Health Unit for three years. She has a variety of experiences in managing health and social services programs. Ms. Ybarra holds a masters degree in organizational management and is a licensed social worker.

Mandy Bakulski, RD is the Prenatal Program Director in the Women's Health Unit. Ms. Bakulski is a registered dietitian and has worked in the field of prenatal health for nearly 10 years. She received her bachelor's degree in Nutrition Science & Dietetics from Colorado State University. Ms. Bakulski has worked at the Colorado Department of Public Health and Environment since 2004, originally as the Director of the Prenatal Plus Program.

Gabriel Kaplan, PhD is the branch director of Epidemiology, Planning and Evaluation. Dr. Kaplan recently joined the Department of Public Health and Environment after spending the last 5 years as an assistant professor of public policy at the University of Colorado, Denver School of Public Affairs. Dr. Kaplan received his Ph.D. in public policy from Harvard University in 2002 and his Masters in Public Affairs from Princeton University in 1994. He has worked as an analyst for the US Senate, for government agencies overseas, and nonprofit clients.

Helene Kent RD, MPH is the SSDI Coordinator. She has over 20 years of experience with the Colorado Department of Public Health and Environment, including previous tenure as the Director of the Women's Health Section within the MCH Program. Ms. Kent was the Director of Assessment and Assurance for the Association of Maternal and Child Health in Washington DC.

An attachment is included in this section.

E. State Agency Coordination

This section describes the MCH Programs relationships with a number of key partners.

Relationships among the State Human Service Agencies

Much of the statewide work accomplished by MCH staff is done in collaboration with other state agency staff, particularly those who work with the Colorado Departments of Education; Health Care Policy and Financing; and Human Services. MCH personnel work with other state agency staff on a daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements. A number of examples of state agency coordination are provided in this section, but this list is not exhaustive. Examples are also provided in other sections, particularly

agency capacity section (III, B) and in the performance measures sections (IV C and IV D).

The Colorado Department of Human Services, in particular the Division of Developmental Disabilities is an essential partner of the Children with Special Health Care Needs Unit within the MCH Program. Together the agencies offer services for children served by the Colorado Department of Human Services and the Health Care Program for Children with Special Needs. Programs include the Colorado Department of Human Services' Early Intervention Colorado; Family Support Services Program for families with a member who has developmental disabilities; Children's Extensive Support Waiver for Children Birth to 18 who are at high risk for out-of-home placement; and the Children's Medical Waiver for Children Age Birth to 18 with Developmental Disabilities that allows access to Medicaid state plan benefits regardless of parental income. The HCP program also works closely with Early Intervention Colorado to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs at the community level. An HCP staff member represents the program and the department on the Interagency Coordinating Council and the state level Memorandum of Understanding committee.

The Women's Health Unit administers the Prenatal Plus Program on behalf of the Colorado Department of Health Care Policy and Financing (HCPF). This program will be administered by HCPF as of July 2011.

The Colorado Department of Education is an essential partner in activities relevant to early childhood state systems building efforts; coordinated school health model; work with school nurses; and school-based health center activities.

The Colorado Department of Human Services, Division of Behavioral Health leads efforts to reduce underage drinking through the Prevention of Alcohol Related Consequences (PARC) Committee (formerly called the Underage Drinking Prevention and Reduction Workgroup). The PARC Committee is responsible for prevention and reduction of underage drinking statewide while increasing intervention and treatment services to all youth, when needed.

Another important partners for work associated with efforts to address teen motor vehicle safety are the Colorado Departments of Transportation; Revenue, Motor Vehicle Division; and Public Safety, State Patrol.

Relationships with Local Public Health Agencies
In recent years there has been great progress in developing Colorado's public health infrastructure. In 2008, the Colorado Public Health Act was passed that requires each of the 64 counties to establish and maintain a public health agency. The state health department's Office of Planning and Partnerships is responsible for carrying out this work via the Colorado's Public Health Improvement Plan - From Act to Action, which is found at http://www.cdphe.state.co.us/opp/cophip.html. The Office works with state- and community-based public health systems to maintain and strengthen statewide infrastructure and capacity to provide comprehensive public health services in the state. The MCH program works through and with the department's Office of Planning & Partnerships to address statewide MCH issues.

The MCH Program uses a comprehensive planning process to support fifteen local public health agencies in developing an MCH operational plan to address community needs. This planning process, developed collaboratively with local public health partners, is a systematic way of planning, implementing and evaluating that ensures that MCH plans at the local level are in alignment with the state-level MCH performance measures and priority CSHCN national outcome measures. Each local public health agency engages in a three-year cycle, that includes one year of intensive planning, followed by two years of implementation that is documented with annual updates to the state office. The three-year cycles are staggered so that five local public health agencies are completing the intensive planning each year.

The state MCH program provides MCH data to each local MCH agency annually to ensure planning is data driven. Counties use evidence-based and/or promising practice strategies with explicit goals, objectives, and activities to address the needs identified through their planning process. Agencies also evaluate their efforts using process and outcome evaluation measures. Go to www.mchcolorado.com for more information.

MCH Action Guides are available to assist local health agencies in developing their MCH operational plans. These action guides provide comprehensive resources for developing strong goals and SMART objectives and for identifying strategies and action steps to address priority health issues. Action Guides related to a variety of key MCH issues are available on the MCH Web site.

Relationships with Federally Qualified Health Centers and Primary Care

The Colorado Community Health Network (CCHN) is the state primary care association that represents Colorado's 15 Community Health Centers (CHC) that are the backbone of the primary health care safety-net in Colorado. CCHN has a Medical Home project that is coordinated with the CSHCN Unit's Colorado Medical Home Initiative to develop common messaging about medical home concepts and to infuse the consumer voice. CHC's operate 138 health care delivery sites in 35 Colorado counties. Colorado's community health centers provided over 1.7 million visits to over 419,000 low-income patients in 2008, many of them women and children. Thirteen CHCs operate 37 dental clinic sites in 21 Colorado counties and provided 175,000 visits. 90 percent of patients served by CHCs have family incomes below 200% of the Federal Poverty Level.

The state health department's Primary Care Office works with CCHN to improve accessibility and expand primary care services to targeted low-income and vulnerable populations. These efforts include information and data sharing; recruitment and retention of health professionals; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

Relationships with Tertiary Care Facilities

The lead partner with tertiary care facilities is the state health department's Primary Care Office. Community health centers are responsible for much of the primary care provided within Colorado. As MCH focus is mainly on public health functions, the relationship with tertiary care facilities has changed. MCH-funded programs work to link families to care within the community, support reforms that increase access to health care, and participate in partnerships to assure adequate systems of care in communities to meet residents' needs.

The CSHCN program still has a strong relationship with specialty health care provision and has prioritized creating medical homes for children and building systems of care in communities, which requires the involvement of hospitals. The Newborn Metabolic Screening Program contracts with The Children's Hospital for follow-up services.

The Women's Health Unit participates on the Colorado Perinatal Care Council (CPCC) a volunteer, non-profit, advisory group whose members represent a variety of professions, hospitals and organizations with an expertise or interest in perinatal care that addresses the coordination and improvement of perinatal care services in Colorado

Available Technical Resources

Colorado is fortunate to have a number of training and technical assistance resources available. Resources include in-house training through the state health department and the new School of Public Health at the University of Colorado Denver. In addition, the CSHCN Unit works with the University of Colorado JFK Partners, a MCH LEND grantee, and Colorado Win Partners, dedicated to workforce development for people with disabilities, to support their technical assistance needs.

Title V Program Coordination with Other Specific Programs
1. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is located at the Colorado Department of Health Care Policy and Financing. The Medicaid Program contracts directly with local public health agencies. The Health Care Program for Children with Special Needs' local and regional care coordinators work closely with EPSDT staff. Typically, EPSDT coordinators work with public health service programs such as WIC, prenatal, immunization services, the Health Care Program for Children with Special Needs, and other child health initiatives. At the state level, Title V continues to work with EPSDT and to participate in the EPSDT State Advisory Board. EPSDT personnel also serve on the Health Care Program for Children with Special Needs Medical Home Advisory Committee.

2. Other Federal Grant Programs
The Nutrition Services Branch, that includes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Child and Adult Care Food Program (CACFP), is in the same division as the MCH program. The programs have worked jointly for many years. Current efforts are focused on increasing breastfeeding rates and decreasing childhood overweight and obesity.

Title X Family Planning is housed within the Women's Health Unit. The MCH Block grant and Title X family planning activities are well-integrated. Efforts to address unintended pregnancy, preconception health and teen fertility are targeted to both family planning and MCH contractors. MCH funds are not used to fund direct family planning services, but rather to support population-based activities around unintended pregnancy prevention.

3. Providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for other services.
The majority of local MCH contractors for Prenatal Plus and the Nurse Home Visit Program also served as presumptive eligibility sites for Medicaid. The Baby Care/Kids Care Program (authorized under Colorado's Medicaid state plan) allowed Medicaid presumptive eligibility determinations to be made at public health sites. MCH contractors identified women and infants who were eligible for Medicaid at the local public health site (through WIC, family planning, EPSDT, etc.), and deemed them presumptively eligible for Medicaid if the income requirements were met. Women are referred to community resources for direct care, case management, and other services.

4. Title V Coordination with the Social Security Administration, State Disabilities Determination Services unit, Vocational Rehabilitation, and Family Leadership and Support Programs Social Security Administration (SSA)
Relationships with the State Determination Unit of the Social Security Administration are strong. Local level EPSDT outreach workers make calls to families of children receiving Title XVI (SSI) to assess whether service and support needs are being met. Referrals are made to the Health Care Program for Children with Special Needs when family needs are complex and the EPSDT outreach worker feels that care coordination by a Health Care Program for Children with Special Needs staff member is appropriate.

Developmental Disabilities
In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. HCP personnel at the community level provide care coordination when families have more complex medical or psychosocial needs.

Vocational Rehabilitation
Relationships with Vocational Rehabilitation have been cultivated through the Colorado Interagency Transition Team that consists of ten stakeholder agencies that work together to

address youth transition to adulthood. A representative from Vocational Rehabilitation sits on CSHCN's Unit's Colorado Health Transition Coalition. Both the Department of Education's Special Education Section and Vocational Rehabilitation are actively involved in the Brain Injury Steering Committee.

Family Leadership and Support
Title V has supported Family Voices Colorado financially and through membership on its board of directors since it became an official chapter in 2001. Family Voices works with the state-level CSHCN family position and local family consultants to implement the Family-to-Family Health Information Network provides state level family advocacy; and represents the parent perspective in developing systems of care. The CSHCN's Unit financially supports the Colorado Families for Hands & Voices to engage in family advocacy, outreach to underserved populations, and parent leadership activities.

Title V Program Coordination with other Specific Programs
The MCH Program works with many other programs. The following list is incomplete, but includes important programs within and external to the state health department. It also includes grant-funded programs associated with the MCH program.

The following programs are external to the health department:
The Healthier Beginnings for African-American/ Black Communities' Project is based at Tri-County Health Department with participation from the Women's Health Unit, Healthy Start, Aurora City Council, March of Dimes, and the community.

The Colorado Association for School-Based Health Care advocates for health care in schools for Colorado's children and adolescents. It is a membership organization that provides policy leadership, training and technical assistance, and quality assurance programs.

The Colorado Breastfeeding Coalition is a volunteer organization comprised of physicians, nurses, public health officials, nutritionists, dietitians, lactation consultants, counselors, and members of the business community. The coalition works to increase breastfeeding initiation and duration rates within the state.

Colorado Children's Healthcare Access Program is a non-profit organization devoted to ensuring that every child enrolled in Medicaid and Child Health Plan Plus (CHP+) receives comprehensive health care from a primary care provider, medical home team, and that all pregnant women covered by Medicaid or CHP+ receive comprehensive prenatal services.

The Colorado Perinatal Care Council is a volunteer, non-profit, advisory group whose members represent a variety of professions, hospitals and organizations with an expertise or interest in perinatal care. Its major focus is the coordination and improvement of perinatal care services in Colorado.

Covering Kids and Families is a coalition aimed at reducing the number of uninsured children. It has a membership of over 300 individuals from over 170 community-based organizations and agencies.

The Family-to-Family Health Information Center is located at Family Voices. It is a federally-funded, family-run center established to provide information and support to families of children and youth with special health care needs and the professionals who serve them.

Healthy Child Care Colorado provides consultation, technical assistance and training for providers of child care in Colorado to enhance their response to the health and safety needs of young children.

HealthyWomen/HealthyBabies is a nonprofit coalition working to improve birth outcomes through

advocacy, collaboration, research and education. The group has active workgroups addressing: access to prenatal care, family planning and enhancing preconception care.

Oral Health Awareness Colorado (OHAC!) is the statewide oral health coalition whose members are professionals representing a wide range of public, private and non-profit organizations interested in advancing oral health care in Colorado.

The following programs are associated with the state health department.
The "Own Your C" youth tobacco prevention and cessation media campaign is a campaign that seeks to help young people make the connection that their choices define who they are and who they will become.

The Teen Driving Alliance, formerly the Teen Motor Vehicle Leadership Alliance, is a multidisciplinary, statewide coalition that formed in November 2005 with the purpose of bringing together different state agencies, local agencies and private partners concerned about teen driving safety.

The Vaccine Advisory Committee for Colorado (VACC) is co-chaired by the Lieutenant Governor and members represent public health, school health, child advocacy, health care, philanthropy and academia. Together they work to increase childhood immunization coverage in Colorado.

The Colorado Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and community advocates who are dedicated to improving the health and well-being of all Colorado adolescents. The Council was commissioned in 1982 by the Department to provide guidance on priorities and use of resources to improve the health and well-being of Colorado's young people.

The Youth Partnership for Health (YPH) is a diverse group of 14-18 year olds from across Colorado, recruited from a variety of schools, local health agencies and community programs to provide feedback and recommendations for public health programs, practices and policies that effect youth.

The following are grant-funded projects within the health department grouped by subject area:

The Child, Adolescent and School Health (CASH) Unit

The Children, Adolescent and School Health (CASH) Unit uses private foundation funding to provide technical assistance to local early childhood councils related to efforts to integrate health into their local early childhood systems building efforts.

The CASH Unit and the department of Health Care Policy and Financing are implementing a five-year evaluation grant of school-based health centers in Colorado funded through the Child Health Insurance Program Reauthorization Act.

Colorado Connections for Healthy Schools is the state's CDC Coordinated School Health initiative. The departments of health and education work together work to build state infrastructure for coordinated school health. CDPHE provides health content expertise and resources for school representatives to integrate into the school environment.

The Early Childhood Systems (ECCS) Grant supports a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age eight and their families. The Early Childhood Colorado Framework and the Framework in Action State Plan were developed to guide the state's systems-building efforts.

Children with Special Health Care Needs Unit

Colorado's Medical Home Initiative is funded by several grant awards. The initiative is dedicated to systems development and links all the Medical Home projects in the state to assure coordination at many levels.

The HRSA State Implementation: Integrated Services for Children with Special Health Care Needs grant project provides $300,000 per year for three years to allow the department to assist communities to overcome local systemic barriers through the use of medical home quality improvement teams. It also supports the goals of the Colorado Medical Home Initiative.

The MCH Early Hearing Detection and Intervention grant project has developed hearing screening follow-up coalitions in ten communities identified as needing to improve follow-up. Hospital birth certificate staff, early intervention and HCP staff were members of the teams. It also allows for the integration databases including the universal newborn metabolic screening and infant hearing screening data; the Birth Defects Monitoring Program; immunization registry; and asthma surveillance data.

Women's Health Unit

The Women's Health Unit was selected by a private donor to receive up to five years of funding as part of the Colorado Family Planning Initiative. Funding is used to expand family planning services and provide long acting reversible contraception to decrease unintended pregnancies

A Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid was developed with the State Tobacco Education and Prevention Partnership to address the high rates of tobacco use among these populations.

Injury and Suicide, Violence Prevention Unit
A Child Injury Prevention Policy Plan was developed by the Injury, Suicide, and Violence Prevention Program through a grant from CDC. The plan includes strategies to enhance Colorado's booster seat law to require that children be secured in booster seats through age eight, or until they are at least four feet nine inches tall. The law passed this year.

The Youth Violence Prevention Program funded by a Youth Violence Prevention Program CDC grant enhances Colorado's capacity to address child and adolescent health through violence prevention. A Violence Prevention Advisory Group consisting of violence prevention experts, state agency leaders, and members of private and nonprofit prevention groups, work with the state health department on the development of a state needs and resources assessment, followed by the construction of a state-wide strategic plan.

The Office of Suicide Prevention received another three years of funding from the Substance Abuse and Mental Health Services Administration to continue and expand Project Safety Net. This grant allows eight community agencies to serve twenty counties by training adults to recognize and intervene with suicidal youth, and to refer those youth to appropriate services. Project Safety Net also includes a youth suicide prevention awareness campaign entitled Start the Conversation.

Colorado Physical Activity and Nutrition
Funded by CDC, the Colorado Physical Activity and Nutrition Program (COPAN) is responsible for implementing the Colorado Physical Activity and Nutrition State Plan 2010. The plan promotes healthy eating and physical activity to successfully prevent and reduce overweight, obesity, and related chronic diseases. COPAN worked collaboratively with the MCH units and WIC on an assessment of evidenced-based practices to impact early childhoold obesity.

F. Health Systems Capacity Indicators

Introduction

The data for a variety of Health Systems Capacity Indicators for Colorado are shown below, along with a brief narrative for each topic.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	65.9	57.7	53.8	46.4	55.0
Numerator	2213	2002	1889	1646	1968
Denominator	335973	347145	350943	354990	358088
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data shown for reporting year 2009 are calendar year 2008 data.

Notes - 2008

Data shown for reporting year 2008 are calendar year 2007 data.

Notes - 2007

Data shown for reporting year 2007 are calendar year 2006 data.

Narrative:

Health Systems Capacity Indicator 01 shows a variable rate of hospitalization for asthma, ranging between 46.4 and 65.9 per 10,000 children under the age of five. Data for reporting year 2009 (calendar year 2008) show 1,968 hospitalizations, a rate of 55.0, the highest rate in three years.

The Colorado Child Health Survey, carried out annually, provides a wealth of data on asthma that contributes to an understanding of asthma beyond what hospitalization data can provide. According to the calendar 2009 survey, 12.4 percent of children ages 2 to 14 were diagnosed with asthma. Among this group, 71.4 percent still had asthma, 6.1 percent were hospitalized for asthma at least once in the past 12 months, 15.1 percent had been to an emergency room or urgent care center for asthma in the past 12 months, and 77.7 percent used a rescue medication. Among those who used a rescue medication, 51.3 percent carried an inhaler to school. Other information on asthma management plans is also available from the survey.

The Child Health Survey has been in place since 2004. With six years of data now available (calendar 2004 through calendar 2009), we can begin to look at trends and begin to have enough surveys to provide data for some large counties. Statewide, the percent of children diagnosed with asthma was 12.4 in 2004, 10.9 in 2005, 12.5 in 2006, 11.9 in 2007, 10.0 in 2008 and 12.4 in 2009. The year to year changes are not statistically significant and the rate is essentially

unchanging.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	80.3	94.1	89.6	92.0	92.5
Numerator	25588	28344	26673	27998	28468
Denominator	31864	30122	29755	30438	30768
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for reporting year 2009 are from the CMS 416 report for the state fiscal year 2009.

Notes - 2008
Data for reporting year 2008 are from the HCFA 416 report for federal fiscal year 2008.

Notes - 2007
Data are from the HCFA 416 report for federal fiscal year 2007.

Narrative:
The percentage of infants on Medicaid who received at least one initial periodic screen increased to 92.5 percent in reporting year 2009 (FY 09). This percentage appears to be the highest achieved since reporting year 2003.

The number of infants on Medicaid declined between reporting year 2005 (FY 05 data) and reporting year 2007 (FY 07 data), but began increasing again in reporting year 2008 (FY 08). Data for reporting year 2009 (FY 09) showed an increase to 30,768, higher than the previous three years but still lower than reporting year 2005 (FY 05).

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0	73.9	0	49.0	54.4
Numerator		965		3979	8090
Denominator		1305		8126	14878
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for reporting year 2009 represent state fiscal year 2009 (July 2008 through June 2009). Children are enrolled in either a state managed care network or a health maintenance organization but tracking between systems is not possible. Consequently, there is some duplication in the reported numerator and denominator.

Notes - 2008
Data for reporting year 2008 represents state fiscal year 2008 (July 2007 through June 2008). Children are enrolled in either a state managed care network or a health maintenance organization but tracking between systems is not possible. Consequently, there is some duplication in the reported numerator and denominator.

Notes - 2007
Data are not available for the period July 2006 through June 2007.

Narrative:
The Colorado Department of Public Health and Environment obtains data for this measure from the Colorado Department of Health Care Policy and Financing. In previous years the data were often not available. Data for reporting years 2008 and 2009 were derived from combining counts of children served in two different systems under the Child Health Plan Plus program: the CHP+ state managed care network and the CHP+ health maintenance organization.

There may be some duplication in the counts of children in the overall CHP+ program as well as some duplication in the number receiving at least one periodic screen, since children cannot be tracked between the two systems.
The average length of coverage on the state managed care network was four months and for the health maintenance organization it was six months. Since the well-child visit schedule for infants recommends visits at 3-5 days, 1, 2, 4, 6, 9 and 12 months, every child in either system should have had at least one periodic screen. The data for reporting year 2009 show just over half (54.4 percent) of children are receiving screenings.

The Colorado Department of Health Care Policy and Financing is expected to continue to provide data for this measure in future years.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	76.6	76.1	74.0	67.0	67.9
Numerator	51193	50881	50889	45976	46002
Denominator	66846	66903	68739	68635	67704
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 data.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data. The Colorado birth certificate was revised in 2007 so that prenatal care is based on medical records rather than self-report. This change yields a lower rate.

Notes - 2007
The data shown for reporting year 2007 are calendar year 2006 data. The denominator is less than the total number of resident births due to missing data needed for the Kotelchuck Index.

Narrative:
Data for reporting year 2009 are taken from the revised 2007 birth certificate. The percentage of women who received adequate care according to the Kotelchuck Index was 67.9 percent, a slight increase from 67.0 percent in reporting year 2008, but still lower than other years shown.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	95.1	76.0	86.5	81.6	78.1
Numerator	340929	237200	266888	210695	216678
Denominator	358435	312107	308431	258298	277517
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data represent children ages 0 through 18 during 2008. Data are available in the Colorado Children's Health Insurance Status: 2010 Update Issue Brief at http://www.coloradohealthinstitute.org/~/media/Documents/sn/EBNEchildren.ashx. The data were derived from an improved methodology for estimating children eligible for Medicaid. These results are not comparable to those reported in RY2008 because the methodology was improved.

Notes - 2008
Data represent children ages 0 through 18 during 2005-2007. Data are available in the Colorado Children's Health Insurance 2009 Update Issue Brief at http://www.coloradohealthinstitute.org/Documents/sn/EBNE.pdf.
These data were derived from an improved methodology for estimating children eligible for Medicaid.

Notes - 2007
Date reported in previous years were based on an estimate. Current data reported reflects actual data for calendar year 2006. The numerator is the number of children enrolled in Medicaid vs. the number of potentially Medicaid-eligible children.

Narrative:
An estimated 78.1 percent of children who were eligible for Medicaid in Colorado were enrolled in the program. The data shown for reporting year 2009 come from an update of an in-depth study done by the Colorado Health Institute in the spring of 2009 using data from 2005 to 2007. The update, completed in Spring 2010, used the U.S. Census Bureau's 2008 American Community Survey data to estimate the number of uninsured Colorado children eligible for Medicaid but not enrolled in Medicaid.

The percentage shown is the total number of children in the Medicaid program compared to the total number eligible for the program. While about 8 in 10 children are enrolled in the program, the data shown do not indicate the number within the program who received a service. Because data on the number of Medicaid-eligible children who received a service paid by the Medicaid program is not available, the percentage of total number of children in the Medicaid program compared to the total number eligible for the program is used as a proxy for this specific capacity indicator.

The full report can be seen at
http://www.coloradohealthinstitute.org/~/media/Documents/sn/EBNEchildren.ashx

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	63.2	49.9	51.5	53.8	57.0
Numerator	46987	32794	34303	37126	45409
Denominator	74333	65757	66603	68974	79616
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are from the CMS 416 report for the state fiscal year 2009.

Notes - 2008
Data are from the HCFA 416 report for federal fiscal year 2008.

Notes - 2007
Data are from the HCFA 416 report for federal fiscal year 2007.

Narrative:
The percentage of EPSDT eligible children age 6 through 9 who have received any dental services during the year showed a sharp increase in reporting year 2005, and fell in reporting year 2006 (federal fiscal year 2006) but otherwise has been increasing. There have been changes in how the Centers for Medicare and Medicaid calculate this statistic, but the value of 49.9 percent (reporting year 2006) is considered to be a more accurate representation of the percent of EPSDT children receiving services than figures prior to 2004. Since reporting year 2006, the percentage of children receiving dental services appears to have increased moderately, reaching 57.0 percent in reporting year 2009 (federal fiscal year 2009). It is worth noting that the number of children age 6 to 9 in the program has also been increasing since reporting year 2006.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	5940	6133	7495	6702	7146
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative services to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2009. The numerator of zero is correct.

Notes - 2008
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative services to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2008. The numerator of zero is correct.

Notes - 2007
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative serices to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2007. The numerator of zero is correct.

Narrative:
The state Children with Special Health Care Needs program stopped paying for rehabilitative services in July 2003. Therefore, 0 percent of state SSI beneficiaries less than 16 years old have received rehabilitative services from the program in all reporting years since then.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight	2008	payment source	9.5	8.6	8.9

(< 2,500 grams)		from birth certificate			

Notes - 2011
Data shown for reporting year 2009 are calendar year 2008 data. Payment source is the principle source of payment of the delivery, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:
Medicaid women are at an increased risk of having a low birth weight infant (9.5 percent versus 8.6 percent). The Medicaid rate is nearly a full percentage point higher than the non-Medicaid rate.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	payment source from birth certificate	7.4	5.4	6.2

Notes - 2011
The infant death rate is based on deaths occurring among calendar 2007 births. Payment source is the principle source of payment of the delivery, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:
Infant death data by Medicaid and non-Medicaid status at delivery became available for the first time in reporting year 2009, following the revised 2007 Colorado birth certificate (which collects Medicaid status) and the end of calendar year 2008 (the earliest time at which one-year infant mortality rates could be calculated). Not unexpectedly, the Medicaid population is at increased risk of infant death. Infants born to women on Medicaid were 37 percent more likely to die within the first year of life compared to infants born to women not on Medicaid. The Medicaid infant mortality rate was a full two points higher than non-Medicaid infant mortality (7.4 deaths versus 5.4 per 1,000 births).

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	63.8	83.9	76.9

Notes - 2011
Data shown for reporting year 2009 are calendar year 2008 data. Payment source is the principle source of payment of the delivery, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:
Medicaid patients enter prenatal care at much later dates than non-Medicaid patients; fewer than two out of three (63.8 percent) begin care in the first trimester compared to 83.9 percent of non-Medicaid patients beginning care early.

The challenge for Colorado is clearly among women whose prenatal care is covered by Medicaid. Numerous obstacles exist for early care for this group, including the application process.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	65.3	69.6	68

Notes - 2011
Data shown for reporting year 2009 are calendar year 2008 data. Payment source is the principle source of payment of the delivery, and does not indicate insurance coverage during pregnancy or imply the source of payment for prenatal care.

Narrative:
This measure reveals that just over two-thirds of all Colorado women receive appropriate care according to the Kotelchuck Index. There is a four-point difference between Medicaid and non-Medicaid women (65.3 versus 69.6), revealing an even greater difficulty among Medicaid women to meet the Kotelchuck standard. Nonetheless, women who are not on Medicaid appear to fall well short of the standard as well.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP**	**YEAR**	**PERCENT OF POVERTY LEVEL**

programs for infants (0 to 1), children, Medicaid and pregnant women.		**SCHIP**
Infants (0 to 1)	2009	250

Notes - 2011
Data for reporting year 2009 are from http://cchn.org/ckf/resources.php.

Notes - 2011
Data for reporting year 2009 are from Colorado Covering Kids & Families. On May 1, 2010, CHP+ was expanded to cover children and pregnant women up to 250% FPL as a result of the Colorado Healthcare Affordability Act passed in Colorado in 2009.

Narrative:
The percent of poverty level for eligibility for infants in Colorado's Medicaid plan is 133 percent, while the level for infants in the Child Health Plan Plus (CHP+) Program rose from 205 percent to 250 percent as of May 1, 2010.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	 250

Narrative:
The percent of poverty level for eligibility for children in the Child Health Plan Plus (CHP+) Program rose from 205 percent to 250 percent as of May 1, 2010.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	250

Narrative:
Presumptive eligibility for children in CHP+ and Medicaid was implemented in January 2008. This change provides children and pregnant women at least 45 days and up to 60 days of immediate coverage as they await final eligibility determination.

The percent of poverty level for eligibility for pregnant women in the Child Health Plan Plus (CHP+) Program rose from 205 percent to 250 percent as of May 1, 2010.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The Prevention Services Division is able to obtain data from most of the data sources listed, and has access to the electronic databases. The Health Statistics Section at the state health department provides much of the data and some of the analysis in addition to the analytical work completed by the staff of the Epidemiology, Planning and Evaluation Branch in the Prevention Services Division.

However, use of the hospital discharge survey data, other than for injury analysis, is limited. More staff resources are needed to make use of the information that is available.

Birth certificates are linked monthly to Medicaid files for the sole purpose of obtaining contact information for births sampled for the PRAMS survey.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes
Colorado Child Health Survey	3	Yes
Colorado Healthy Kids Survey on Tobacco	3	Yes

Notes - 2011

Narrative:
The Colorado Youth Risk Behavior Survey provides data on adolescent tobacco use every other year. The sample size in 2005 and 2009 was large enough for valid statewide estimates, but the sample size in 2007 fell short. It is hoped that adequate sample size will allow for weighted data again in the future.

Child Health Survey data are collected by the Health Statistics Section at the state health department and provided annually. Results are tabulated in the spring of the year following the survey, which is conducted on an on-going monthly basis. Data for 2008 were made available in June 2009; data for 2009 were available in May 2010. Because the Child Health Survey is administered at the Colorado Department of Public Health and Environment, the results are available quickly, which greatly enhances program planning.

The Colorado Healthy Kids Survey on Tobacco (CHKS-T) was first conducted in fall 2001 and was repeated in fall 2006 and 2008.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section of the grant provides detailed information on Colorado's priorities in maternal and child health. The priorities are addressed through both national and state performance measures. There are a total of 18 national measures and 10 state measures. Each of these is discussed in detail under each measure's heading (Sections IV C and D).

B. State Priorities

This section addresses Colorado's State Performance Measures and the attachment lists the state priority needs along with the corresponding State and/or National Performance/Outcome Measures that will be used to evaluate progress. Each of the priorities is linked with at least one and sometimes multiple state and national measures. The state measures were chosen since, in all but one case, current population data sets (e.g., vital statistics, PRAMS, the Colorado Child Health Survey, BRFSS and/or YRBS) included data that aligned with the state performance measure. Wording used in a number of the state performance measures mirrors that used in the data source.

2011 - 2015 Colorado's Nine Priorities and Ten Accompanying State Performance Measures
Priority 1: Promote preconception health among women and men of reproductive age with a focus on intended pregnancy and healthy weight.
•SPM 1: Percentage of sexually active women and men ages 18-44 using an effective method of birth control to prevent pregnancy. (BRFSS)
•SPM 2: Percentage of live births to mothers who were overweight or obese based on BMI before pregnancy. (Birth certificate)

Priority 2: Improve screening, referral and support for perinatal depression.
•SPM 3: Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery. (PRAMS)

Priority 3: Improve developmental and social emotional screening and referral rates for all children ages birth to 5.
•SPM 4: Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5. (Child Health Survey - CH169)
•SPM 5: Percentage of Early Intervention Colorado referrals coming from targeted screening sources. (Early Intervention Colorado)

Priority 4: Prevent obesity among all children ages birth to 5.
•SPM 6: Percentage of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI. (Birth certificate)

Priority 5: Prevent development of dental caries in all children ages birth to 5.
•SPM 7: Percent of parents reporting that their child (age 1 through 5) first went to the dentist by 12 months of age. (Child Health Survey - CH63a)

Priority 6: Reduce barriers to a medical home approach by facilitating collaboration between systems and families.
•There is no state performance measures associated with this priority. However, this priority is measured by National Performance Measure 3 -- The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (National CSHCN Survey) and National Outcome 2 -- All Children will receive comprehensive, coordinated care within a medical home.

Priority 7: Improve sexual health among all youth ages 15 -19.
•SPM 8: Percentage of sexually active high school students using an effective method of birth control to prevent pregnancy. (YRBS)

Priority 8: Improve motor vehicle safety among all youth ages 15 -- 19.
•SPM 9: Motor vehicle death rate for teens ages 15-19 yrs old.

Priority 9: Build a system of coordinated and integrated services, opportunities and supports for all youth ages 9-24.
•SPM 10: The percentage of group members that invest the right amount of time in the collaborative effort to build a youth system of services & supports. (Wilder Collaborative Factor Inventory)

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	213	77	54	63	60
Denominator	213	77	54	63	60
Data Source				CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data shown for reporting year 2009 are based on calendar year 2008 births.

Notes - 2008
Data shown for reporting year 2008 are based on calendar year 2007 births.

Notes - 2007
Data shown for reporting year 2007 are based on calendar year 2006 births.

a. Last Year's Accomplishments
The target for reporting year 2009 was for 100.0 percent and 100.0 percent was achieved. The target was met (using calendar 2008 data). A total of 60 screen positive newborns received timely follow up to definitive diagnosis and clinical management for their conditions.

DNA Mutation Analysis was added to the Cystic Fibrosis (CF) screening program, a side-effect of which is the identification of children who are CF carriers (carriers of genes that cause CF). Parents who have a child who is a CF carrier benefit from education and counseling about their risk of having a child with CF. The newborn screening follow-up program offered genetic counseling to the parents of infants found to be CF carriers. Counseling was provided on the phone and/or by letter. In the period from October 2008 to September 2009 approximately one dozen children were found to be CF carriers.

Cross training between the newborn metabolic screening follow-up and the newborn hearing screening follow-up coordinators was initiated and was ongoing.

In June 2009, the members of Colorado's Newborn Metabolic Screening Advisory Committee were interviewed for a National Institutes of Health National Human Genome Research Institute project, "Methods for Promoting Public Dialogue on the Use of Residual Newborn Screening Samples for Research." The study's purpose was to conduct a comprehensive assessment of health department policies and procedures relevant to retention of residual newborn screening samples and the role of public input on policy development. The advisory committee members were interviewed to assess the role of state newborn screening advisory committees in policy development and/or management decisions regarding retained samples.

The Colorado Department of Public Health and Environment (CDPHE) Laboratory, the Immunization Registry, and the Newborn Metabolic and Newborn Hearing Screening Follow-up programs continued to investigate the integration of newborn metabolic and newborn hearing results with the immunization registry. Positive newborn metabolic results are sent to the primary care provider. Newborn hearing screening results are reported on a child's birth certificate. Discussions were deferred by the Immunization Program due to the emergent needs of dealing with the H1N1 flu virus.

Colorado is one of four states awarded a HRSA Cooperative Agreement entitled, "Effective Follow-up in Newborn Screening" (HRSA-09-242). This project supports collaboration among the CDPHE, the Inherited Metabolic Diseases (IMD) clinic at The Children's Hospital, local and state health personnel, and primary care providers to enhance the statewide newborn screening program. It also enhances the care of patients diagnosed with an inborn error of metabolism via newborn screening. The purpose of the proposal is four-fold: to ensure that all children in the State of Colorado receive newborn screening and have access to follow-up services; to enhance the newborn screening program within the state via an integrated health information exchange system; to explore interstate connectivity and data sharing; and to assure ongoing comprehensive care via the medical home.

The state has been reporting an unacceptably high number of false positive screens for Congenital Adrenal Hyperplasia (CAH). False positive screens are those that do not result in a diagnosis. Such a high number of false positive screens created a climate in which physicians have not been treating abnormal screens for CAH as meaningful and have therefore been delaying timely retesting. The lab has improved testing methodology and the number of abnormal screens has dropped from five a day to three a week, eliminating the problem.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Added DNA mutation analysis to the Cystic Fibrosis (CF) screening program				X
2. Continued to investigate the integration of newborn metabolic and newborn hearing results with the immunization registry				X
3. Received and carried out the Effective Follow-up in Newborn Screening grant	X	X	X	X
4. Reduced the rate of false positive screens for Congenital Adrenal Hyperplasia				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 100.0 percent.

The composition of the Newborn Screening Advisory Committee is being reviewed to ensure that all professional and lay groups involved in newborn metabolic screening are represented.

The newborn hearing screening follow-up coordinator position is vacant. Certain responsibilities and duties of the newborn metabolic screening follow-up and the newborn hearing screening follow-up coordinators are being reapportioned to maximize efficiency and optimal use of resources. The job duties of this position are being reassessed and a new job description is being created prior to hiring for the position, which will be accomplished before September of 2010. The new job description solidifies the reapportioning of the two positions' responsibilities and duties.

The newborn screening laboratory and the newborn screening follow-up program have recently written a Newborn Screening Report 2009 at the behest of the state's Chief Medical Officer. The report is a tool to educate legislators and others about the program and about newborn metabolic screening. The report includes a history and timeline of the state's screening program, explanations of the conditions on the panel, an explanation of specimen collection, statistics on the number of cases of disease found as a result of newborn screening, and human interest profiles of children identified with disease through the screening program.

c. Plan for the Coming Year
The target for reporting year 2011 is 100.0 percent.

Colorado's newborn screening program will add screening for Severe Combined Immunodeficiency (SCID) by July 2011. In anticipation, the state lab will hire a dedicated scientist. The follow-up program will take advantage of educational opportunities; design a follow-up protocol; and contract with a pediatric immunologist to provide immediate consultation with a child's primary care provider to assist with diagnosis and clinical management of newborns with abnormal newborn screens for SCID. A similar arrangement exists within the screening program for abnormal screens for congenital hypothyroidism and congenital adrenal hyperplasia. The arrangement has significantly reduced the age at which children are diagnosed and treated for these conditions, thereby maximizing the benefits of newborn screening. The precedent for such an arrangement came from the Arizona newborn screening program. Before the addition of an immediate specialist consult for hypothyroidism was initiated in Colorado, the average age of treatment was 20 days, with a range up to 148 days. After the specialist referral began, the average age was reduced to 12 days. Treatment before six weeks of age (42 days) is compatible with normal cognitive development, while treatment before three weeks of age (21 days) is the current goal of pediatric endocrinologists. Thirty cases of congenital hypothyroidism are

diagnosed annually.

The newborn screening laboratory will add a web access feature to allow certain entities, such as submitting laboratories and contracted subspecialists, to view newborn screening results on line. The lab will pilot the system with the laboratories of the state's largest birthing centers. The Inherited Metabolic Diseases Clinic, the Sickle Cell Treatment and Research Center, the Division of Pediatric Endocrinology at Children's Hospital and Pediatric Endocrine Associates, as contractors of the health department, will have access to results.

Goals and activities associated with the HRSA "Effective Follow-up in Newborn Screening" grant will be initiated. These activities include increasing access to biochemical genetic services for all newborns. Investigation of the utility of health information exchange system for certain newborn screening disorders. Assessment of the feasibility of data sharing with other states and integration with other established health information exchange systems. Populate the newborn screening database with information obtained from vital statistics, the state laboratory, and clinical care information for patients diagnosed via expanded newborn screening since July 2006. A final project is to explore using the Mountain States Genetics Regional Collaborative Center's Metabolic Consortium as a resource to address regional care and service issues.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**70525**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	70169	99.5	44	2	2	100.0
Congenital Hypothyroidism (Classical)	70169	99.5	52	30	30	100.0
Galactosemia (Classical)	70169	99.5	1	0	0	
Sickle Cell Disease	70169	99.5	9	8	8	100.0
Biotinidase Deficiency	70169	99.5	4	4	4	100.0
Cystic Fibrosis	70169	99.5	13	13	13	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	70169	99.5	57	3	3	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.4	57.4	57.4	60	60
Annual Indicator	57.4	57.4	59.1	59.1	59.1
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	61	61	61	61

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting year 2007 and 2008.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The target for reporting year 2009 was 60.0 percent and 59.1 percent was achieved. The target was not met. The annual indicator showed that 59.1 percent of families with children with special health care needs partnered in decision making at all levels and were satisfied with the services they received.

In February 2009, a pilot program for the Family Leadership Training Institute (FLTI) was launched in Arapahoe/ Douglas and Adams counties. Over 40 applications were received and 29 people were selected to participate in the two classes. Twenty-six family leaders completed the program. Two credentialed facilitators and one site coordinator were assigned to each class. All class participants were required to plan and implement a community project. Preliminary evaluation information indicates that two participants pursued higher education; six people entered new careers; and two individuals found funding and continued to work on their community projects. In general, FLTI participants continue to network and meet on a regular basis, with many taking leadership and being active participants in their community.

Both FLTI programs sponsored local graduation events that were attended by local elected officials and community members. In June 2009, Children with Special Health Care Needs Unit (CSHCN) sponsored a state graduation event, recognizing all 29 graduates of the Institute. It was attended by the Lieutenant Governor, the Speaker of the Colorado House of Representative, state representatives and several family leaders.
Colorado's Family Leadership Coalition expanded to nearly 20 organizations and individuals including: the Office of the Lieutenant Governor, JFK Partners (AUCD), the Civic Canopy Project, Association of Family Resource Centers, the Partnership for Families and Children, the regional HHS Administration for Youth and Families, Early Childhood Councils of Colorado, PTA of Colorado, Colorado Statewide Parent Coalition, Department of Child Welfare, Department of Human Services, and several family leaders.

In October 2008, nearly 200 people attended a Colorado Summit on Cultural Competence featuring Wendy Jones from the National Center for Cultural Competence. A follow-up session was held in April 2009 to provide continued technical assistance to communities and agencies. The Children with Special Health Care Needs Unit and the Colorado Developmental Disabilities Council jointly sponsored the project.

The Colorado Family Leadership Registry was developed as a tool for families, agencies, communities and policymakers. Nearly 100 family leaders are part of the registry. The registry was designed to encourage meaningful family participation in organizational activities by linking trained family leaders with agencies seeking this assistance. Registry members are graduates of the Family Leadership Training Institute (FLTI) or other skill-based programs. The Department of Education used trained family leaders to serve as facilitators during their three day conference, Parents Encouraging Parents.

Regional family coordinators continued to serve as members of local Health Care Program for Children with Special Health Care Needs public health teams. Statewide services were provided through 16 regional offices and each office has a family coordinator. These Regional Family Coordinators participate in agency planning activities, prepare newsletters, facilitate support groups, and offer resource and referral services directly to families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Launched two pilot projects for the Family Leadership Training Institute in Arapahoe/ Douglas and Adams Counties with 26 family leaders completing the program		X	X	
2. Expanded to nearly 20 organizations and individuals the Colorado Family Leadership Coalition				X
3. Offered a Summit on Cultural Competence that was attended by 200 people			X	
4. Continued to expand the Colorado Family Leadership Registry			X	
5. Continued to included a family coordinator in each CSHCN regional team throughout the state	X	X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2010 is 60.0 percent.

Efforts to continue to expand the Family Leadership Registry were halted due to funding cuts. The project will restart when additional funding sources are restored.

In October 2009, the CSHCN Unit sponsored a train-the-trainer event to increase the number of credentialed facilitators for the Colorado Family Leadership Training Institute. Over 60 individuals attended including: participants from other states (Wyoming, Montana, Virginia, and New Mexico); civic leader representation from Colorado; and staff from the Association of Maternal and Child Health Program and the Family Voices national offices.

The Family Leadership Training Institute was again offered in Arapahoe/Douglas, and Adams counties. Three new sites were added in Larimer, Denver Metro and Montezuma/Dolores counties. Nearly 100 students with varying levels of education, social economic status, and previous civic engagement experience were enrolled.

Two family leaders, graduates of FLTI training, were appointed to the Governor's Early Childhood Commission.

A HRSA/MCHB TBI grant was received to support state infrastructure and staffing of the FLTI program.

Youth Leadership Council members were trained to develop effective presentations and participated in a training offered by the National Center for Youth Transition. Members offered presentations at a MHAB meeting and a statewide MCH meeting.

c. Plan for the Coming Year
The target reporting year 2011 is 61.0 percent.

Activities from the previous year will continue.

The Early Childhood State and the Prevention Leadership State Plans will be implemented.

The Family Leadership Coalition will work on a unified strategic plan that encompasses statewide activities related to family leadership development.

The Family Leadership Training Institute (FLTI) will expand to three more sites by July 2011. Three of the original sites will offer two classes per year. The program will be expanded to additional sites as funding is available.
Work will begin again on expanding the Family Leadership Registry.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	51.7	51.7	51.7	51.7	51.7
Annual Indicator	51.7	51.7	48.2	48.2	48.2
Numerator					
Denominator					
Data Source				National	National

				Survey of CSHCN	Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	51.7	52	52	52	52

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The target for reporting year 2009 was 51.7 percent and 48.2 percent was achieved. The target was not met. The annual indicator showed that 48.2 percent of children with special health care needs received coordinated, ongoing, comprehensive care within a medical home.

Colorado's Medical Home Initiative began in 2000, the state has benefited from several grant awards, including the Colorado Children's Health Access Program, Patient Centered Medical Home demonstration project and the Safety Net Medical Home Project, all primarily funded by Colorado foundations as well as the Commonwealth Fund. The CMHI links with all the Medical Home projects in the state to ensure coordination at many levels. The CMHI is dedicated to systems development, while the other Medical Home projects are focused on clinical/practice improvement. The CMHI has a cross-agency group of stakeholders, Colorado Medical Home Advisory, and a leadership group, CMHI Steering Committee, who both meet monthly. The Medical Home Advisory has two work groups, the Provider Practice Management (PPM) Task Force and the Family Leadership Task Force that work on project and systems integration issues with partner representation. The PPM Task Force assisted in the development of a request for proposal to assure medical home concepts were included in the Accountable Care Collaborative (ACC) being developed by the Department of Health Care Policy and Financing. A matrix identifying resources and supports available to providers was also developed by the PPM task force. The Family Leadership Task Force reviewed marketing materials and provided consumer feedback on the development of the Colorado's early childhood system's website.

CMHI convened an ad-hoc group that included decision makers from multiple agencies to discuss shared goals. The group, known as the Systems Thinkers, identified four focus areas related to successful implementation and coordination of medical home projects. The group agreed to: develop consistent messaging across agencies; create a shared vision among all medical home projects; develop strategies to change behaviors of patients/families and providers; and consider

the return on investment for medical home implementation from a collaborative perspective. Another outcome was the development of a Medical Home Leadership group that meets monthly to address the priorities.

A medical home brochure was drafted for families to provide a consistent message. It was developed jointly by several medical home projects and partners. The CMHI received the HRSA/MCHB Integrated Services Grant allowing the development of medical home system in four counties (Boulder, Summit, Larimer, and Mesa). These communities identified strengths and barriers to a sustainable medical home system for all children and families in their areas and then developed a plan to address issues. Boulder county braided grant funding with another grant to develop a local-based leadership team to address local systems building effort using a medical home approach for children enrolled in Medicaid and SCHIP. Summit County focused on expanding the number of providers who accept public insurance. Boulder and Summit counties presented their finding and recommendations to the Medical Home Advisory in March 2010. Mesa and Larimer counties action plans will be implemented in the coming year.

The CMHI has developed a Youth Leadership Council composed of youth with special health care needs from several communities across the state. The Youth Leaders have received technical assistance and mentoring from the National Center on Transition.

A comprehensive strategic planning document including logic models, work and evaluation plans was developed to address five core focus areas (content, components, connections, infrastructure, and scale) needed to evaluate a systems development initiative. The plan is based upon the BUILD model for systems development.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to coordinate the Colorado Medical Home Initiative				X
2. Drafted a medical home brochure for families		X		
3. Participated in a HRSA sponsored workshop			X	
4. Received a HRSA/MCHB Integrated Services Grant allowing the development of medical home system in four counties			X	X
5. Initiated a Youth Leadership Council composed of youth with special health care needs				X
6. Developed a strategic planning document to evaluate a systems development initiative				X
7.				
8.				
9.				
10.				

b. Current Activities
The 2010 target is 51.7 percent.

The CMHI continued to implement the strategic planning document for systems development. Work focused on the "connections" core area that creates strong and effective linkages across systems. The CMHI through the work of the Systems Thinkers and the Medical Home Leadership groups continued to coordinate across the myriad of medical home projects. Primary areas of focus are assuring consistent messaging, family and youth involvement, family and youth leadership development, and evaluation of collaboration.

Through the MCHB Integrated Services grant, CMHI continued to evaluate the local systems

building activities. The communities increased family and youth involvement by actively including families/youth perspectives in all local community team activities. The Boulder County group established a sustainability plan to continue the work of the Medical Home Action Team. The Larimer County team is integrating the medical home team approach with their local human services to assure that children in foster care receive a Medical Home Team Approach. In addition, Larimer County has established an outreach and marketing task force to assure consistent messaging throughout their community.

The CMHI continues to sponsor the Colorado Medical Home Advisory to share best practice models and strategies.

CMHI developed a website www.ColoradoMedicalHome.com as a repository for medical home resources for families, communities, and providers.

c. Plan for the Coming Year
The target for reporting year 2011 is 52.0 percent.

The CMHI will continue to convene and coordinate medical home projects.

The development of the Medical Home Team Approach will continue. Priorities include care coordination, systems building, and the reduction of community level barriers to developing a medical home approach.

The funding of the three-year HRSA/MCHB Systems Integration grant will end in May 2011 and sustainability of the projects will be a priority. Boulder County has embedded the work of their Medical Home Action Team within the local health department. Larimer County activities are part of the Department of Human Services/Foster Care Division. Mesa County has integrated the team approach message within all their supplemental medical home projects. Summit County continues to encourage local providers to accept Medicaid and SCHIP.

Training and materials development will continue. Two training curricula will be developed: a Medical Home Team Approach orientation and the other on care coordination. These curricula are sponsored by the University of Colorado Health Sciences Center, College of Nursing and CSHCN Unit staff will lead content development.

The two Colorado Medical Home Advisory task forces (Provider/Practice Management and Family Leadership) will be restructured to function more as in-house advisory groups.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	58.2	58.2	58.2	60	60
Annual Indicator	58.2	58.2	59.1	59.1	59.1
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	61	61	61	61

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The target for reporting year 2009 was 60.0 percent and 59.1 was achieved. The target was not met. The annual indicator showed that 59.1 percent of families with children with special health care needs had adequate private and/or public insurance to pay for the services they needed.

CSHCN staff continued to participate with the Medicaid and Kids and the Covering Kids and Families Coalitions to
share information, simplify the public insurance application process, and identify concerns for families using public insurance.

The Blue Ribbon Policy Council published the Colorado State Strategic Plan for Early Childhood Mental Health in November 2008 that included strategies related to coverage. The recommendations incorporated a prevention and health promotion model.

The System of Care Collaborative of Colorado, consisting of various community partners concerned with the mental health needs of children and their families, worked on reducing the barriers to care. Action centered on developing language for agreements between community partners that strengthen access to care for children and their families.

State CSHCN staff participated on the state public health department's Maternal and Child Health Access to Care Task Force to assess the outcome of local public health's efforts in assisting families with the presumptive eligibility and enrollment processes associated with Medicaid and CHP+.

As part of Colorado Medicaid reform activities, the unit kept apprised the state's Accountable Care Collaborative project. The Accountable Care Collaborative (ACC) is a client-centered approach to managed care focused on delivering efficient and coordinated care that improves the overall health of clients. This model of care differs from capitated managed care by investing directly in community infrastructure to support care teams and care coordination and creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The start date for the ACC Program is January, 2011. Possible contractors were identified that

can contract with local ACC agencies. Regional/local health care providers may contract for care coordination services and may choose to work with local HCP offices. The CSHCN Unit continues to follow the implementation of this state-based Medicaid reform to assure that CSHCN have access to care coordination services. Technical assistance regarding this process was provided to local CSHCN contractors as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in Medicaid and Kids and the Covering Kids and Families Coalitions				X
2. Continued to train and provide updates for community-based sites and partners on policy and program changes for enrollment		X	X	
3. Worked to expand the number of providers accepting public insurance reimbursement and to become medical homes for children				X
4. Defined Medical Home Standards and increased the number of participating Medicaid providers				X
5. Explored how to support access to mental health services			X	X
6. Participated on the CDPHE, Maternal and Child Health Access to Care Task Force				X
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2010 is 60.0 percent.

As part of Colorado Medicaid reform activities, the unit responded to a request for information about CSHCN case management services from the Department of Health Care Policy and Financing (HCPF), Medicaid Accountable Care Collaborative.

The Medical Home Initiative continued to improve provider ability to offer timely and culturally responsive family-centered care within the Medical Home by sharing best practice information and addressing barriers to services.

The Medical Home Advisory (MHA) Board, Provider Practice Management Task Force completed a survey and document, Resource and Supports for Primary Care Providers.

As part of a MOU with HCPF, the Colorado Department of Public Health and Environment (CDPHE) continues to receive Colorado Medicaid data regarding children enrolled in Medicaid.

Through a HRSA systems integration grant, the CSHCN Unit and Colorado Child Healthcare Assistance Program (CCHAP) worked together to increase the number of providers willing to accept public insurance reimbursement and become medical homes. Participating providers receive a Medicaid pay for performance incentive for well child checks completed using the Medical Home Index and participating in a quality improvement project.

Colorado Child Healthcare Assistance Program and Family Voices developed the Provider Resource Helpline for health care providers who work with the program.

c. Plan for the Coming Year
The target for reporting year 2011 is 61.0 percent.

The CSHCN Unit at CDPHE will work with state EPSDT, CCHAP and Family Voices to evaluate the success of the new Provider Resource Helpline. The unit will also provide technical assistance regarding making appropriate referral for care coordination services with the Health Care Program for Children with Special Health Care Needs.

The unit will work with Connecting Kids Colorado, EPSDT and Family Voices to stay apprised of health care reform implementation in Colorado. There is exciting potential to significantly improve access to health care for CSHCN and their families with the new health care reform law. The expansion of Medicaid, Medicaid buy-in, simplification of Medicaid Waivers and increased community and home based services will greatly increase access to health care for this population. Increased funding for individuals with disabilities, community health centers, and mental health services will support reducing out of pocket expenses for CSHCN. Information and guidance will be provided to local CSHCN contractors for care coordination services and local system efforts as this health care reform is implemented in new or current health systems in Colorado.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77.4	77.4	77.4	87.8	87.8
Annual Indicator	77.4	77.4	87.8	87.8	87.8
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	89	89	89	89

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The target for reporting year 2009 was 87.8 percent and 87.8 percent was achieved. The target was met. The annual indicator showed that 87.8 percent of families with children with special health care needs reported the community-based service systems are organized so they can use them easily.

The Children with Special Health Care Needs Unit of programs includes The Health Care Program for Children with Special Needs (HCP), the Colorado Medical Home Initiative (CMHI), Newborn Screening Programs, and the Family Leadership Initiative.

The CMHI began the second year of the HRSA State Implementation: Integrated Services for Children with Special Health Care Needs grant project. The local medical home improvement teams in the first year sites, Boulder and Summit counties, continued to address barriers to the medical home approach and to identify strategies to sustain the teams. The second year sites, Larimer and Summit Counties, identified local systems barriers and developed measurable objectives to address them. All communities obtained an increased reimbursement rate for EPSDT well-child visits for private primary care providers. Boulder County was able to increase EPSDT capacity by integrating some programs and projects. Year two sites included youth and families in their local teams. The new participants offered realistic perspective and active participation in solving problems. Year two sites received ongoing consultation and evaluation from the state implementation team.

The MCH Early Hearing Detection and Intervention grant project developed hearing screening follow-up coalitions in ten communities identified as needing to improve follow-up. Hospital birth certificate staff, early intervention and HCP staff were members of the teams. A referral and follow-up tool was developed customized for each community hospital's protocols and each family's needs. The tool was developed in coordination with Families for Hands and Voices advocacy organization. Results are being analyzed and will be reported in July 2010.

CSHCN national survey data was used to develop outcomes for care coordination. Three levels of care coordination were defined to better assess activities and capacity of the local offices. CHIRP (Clinical Health Information Records of Patients) data indicates 8,909 families received care coordination services from October 2008 through September 2009.

Adams and Arapahoe counties implemented the Family Leadership Training Institute (FLTI) and provided the eleven-week training. These parent leaders worked with local HCP projects to assure family/consumer involvement in health care and medical home projects.

Respite care programs continued in six communities. Two local HCP staff began a statewide Respite Care Coalition. A state survey was conducted to identify respite care needs across the state. There were 250 responses to the survey that indicated parents needed more time together; that it is difficult for families of CSHCN to maintain current or full-time employment, and physical health was affected by the challenges of care.

The CHIRP data indicated there were 2,428 community encounters by public health contractors with other providers, agencies, and organizations to organize services for ease of use by families. Access to specialty medical providers was addressed through 99 Specialty Clinics (Orthopedic 8, Neurology 64, Cardiology 5, Rehabilitation 18, and Pediatric 4). There were 1,116 total completed patient visits offered through 14 specialty clinic sites in 13 counties.

The Developmental Evaluation Clinic program operates in eight sites statewide. The program developed community plans to coordinate with primary care providers and to offer care coordination for families needing these clinic services. A developmental pediatrician provided care in eight sites and saw 302 children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Carried out the second year of the HRSA State Implementation: Integrated Services for Children with Special Health Care Needs grant project		X	X	X
2. Used CSHCN national survey data to develop outcomes for care coordination				X
3. Implemented the Family Leadership Training Institute in Adams and Arapahoe counties		X		X
4. Continued respite care programs in six communities	X	X		
5. Coordinated 2,428 community encounters by public health contractors with other providers, agencies and organizations to organize services for ease of use by families	X	X		
6. Coordinated 99 specialty clinics (Orthopedic 8, Neurology 64, Cardiology 5, Rehabilitation 18, and Pediatric 4) and 1,116 total patient visits were completed through 14 specialty clinic sites in 13 counties	X	X		
7. Operated a developmental evaluation clinic program in eight sites statewide and 302 children were seen by a developmental pediatrician	X	X		
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2010 is 88.0 percent.

The Integrated Services grant year-one communities presented a poster session at the Colorado Public Health Association Annual Conference in October 2009. A presentation was also made at the Colorado Medical Home Initiative Advisory Board in March 2010.

Between November and May the HCP program has developed a new mission and vision, an on-line orientation, and a minimum program standards project is currently in progress.

Statewide trainings for HCP care coordination service staff including the Traumatic Brain Injury Care Coordination Project took place between September and February 2010. The trainings addressed: definition of three levels of care coordination; an overview of the intake process; identification of priority unmet needs; assessment of needs; and identification of interventions.

Five communities offered the Family Leadership Training Institute leadership development. One hundred and twenty people have graduated and 38 percent of participants have children with special needs.

c. Plan for the Coming Year

The target for reporting year 2011 is 89.0 percent.

The HCP program will collect data to evaluate unmet needs related to ease of system use. A training will then be designed so that local communities can begin working to reduce local systems barriers.

HCP clinic services is considering developing a telemedicine project with The Children's Hospital to meet the growing needs of rural communities for pediatric neurology services.

The Family Leadership Training Institute may be expanded into five new communities.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	12	14	47	48
Annual Indicator	5.8	5.8	47	47	47
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	48	49	49	49	49

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
The target for reporting year 2009 was 48.0 percent and 47.0 percent was achieved. The target was not met. The annual indicator showed that 47.0 percent of youth with special health care needs received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Children with Special Health Care Needs local agency team members participated in interagency transition team meetings and increased awareness of Medical Home Approach among members. Teams also provided materials, resource information, and referral services at school-sponsored transition fairs.

Six local agencies addressed transition needs through their systems building efforts and care coordination services. State staff continues to work with regional teams that have identified transition as a local priority.
The Colorado Medical Home Initiative has a Youth Leadership Council Development Team. The team has helped to review and modify materials related to transition to adult services. Team members participated in three trainings offered by the National Center for Youth Transition.

A Youth Leadership Council was developed through the HRSA Integrated Services grant project. Five youth leaders worked with a mentor to learn leadership and presentation skills. The youth council's goal is to develop presentations to state and community groups about medical/health transition.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distributed resource materials to families, providers and community partners that promotes health care transition		X		
2. Continued to establish minimum standards to address health care transition needs through care coordination services				X
3. Continued work to promote Medical Home principles			X	X
4. Addressed transition needs specifically in six local agencies through their systems building efforts and care coordination services		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 48.0 percent.

Minimum standards for care coordination are being updated and will include objectives regarding the transition to adult care services and systems. Similarly, guidelines for MCH sponsored Specialty Clinics and Diagnostic & Evaluation Clinics will include objectives for transitioning youth with special health care needs to adult independence.

The Colorado Youth Development Team surveyed 400 youth-serving professionals representing all Colorado counties and 348 surveys were returned. The recommendations are being used to guide strategic planning for incorporation of positive youth development practices into services for youth. Six local agencies addressed transition needs through their systems building efforts and care coordination services. State staff continues to work with regional teams that have identified

transition as a local priority.

Tri-County Health Department, which serves three metro counties, worked with Adams County high schools to develop a transition packet resource that will help educate youth and their parents about this issue. In Arapahoe County, work is underway to better integrate health care needs into transition planning for youth with special needs.

The Health Care Program for Children with Special Needs developed a weekly web based tool to alert state and local staff of upcoming events. Information about health care transition was included.

The Youth Leadership Council continues to meet.

c. Plan for the Coming Year
The target for reporting year 2011 is 49.0 percent.

The CSHCN Unit will continue to promote health care transition planning as an essential element of a Medical Home Team Approach. Trainings will be offered to local agency staff regarding implementing the revised minimum standards for care coordination that include objectives for transition to adult independence.

State and local agency staff will continue to work together to further address this area.

The Tri-County Health Department transition packet will be shared statewide and the school/public health collaboration will continue.

The Youth Leadership Council will work collaboratively with other MCH-sponsored adolescent health groups such as the Youth Partnerships for Health.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	85	80
Annual Indicator	77.1	83.4	80	78.6	79.4
Numerator					
Denominator					
Data Source				2007 National Immunization Survey	2008 National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	80	80	80	80	80

Notes - 2009
Data shown for 2009 are for the 4:3:1:3:3:1 series for calendar year 2008 from the National Immunization Survey. See http://www2a.cdc.gov/nip/coverage/nis/nis_iap2.asp?fmt=r&rpt=tab29_43133_race_iap&qtr=Q1/2008-Q4/2008. Targets for future years are all set at 80 percent.

Notes - 2008
Data shown for 2008 are data for the 4:3:1:3:3 series for calendar year 2007 from the National Immunization Survey. See http://www.cdc.gov/vaccines/state-surv/imz-coverage.htm#nis.

Notes - 2007
Data shown for 2007 are data for the 4:3:1:3:3 series for calendar year 2006 from the National Immunization Survey. See http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis.

a. Last Year's Accomplishments
The target for reporting year 2009 was for 80.0 percent of 19 to 35 month olds to receive the full schedule of age appropriate immunizations. This target has been reduced from the targets shown in previous years to better reflect the percentage of children who receive all appropriate immunizations rather than the percentage that should receive each indicated vaccine. The annual indicator for reporting year 2009 showed that 79.4 percent of 19 to 35 month olds received the full schedule of age appropriate immunizations. The target was not met.

The Colorado Immunization Information System (CIIS) was physically relocated from the University of Colorado at Denver to the Colorado Immunization Program at the Colorado Department of Public Health and Environment. This move represented the beginning of an evolution of the registry from an academic to an integrated core public health program.

Legislation was passed to expand the Colorado Immunization Information System (CIIS) to include vaccinations for all ages. This expansion allows CIIS to receive and retain vaccine records for all patients.

New state funding allowed the state's local health departments and county public health nursing services to improve their infrastructure for administering and tracking immunizations. Competitive grants were awarded to local public health agencies that proposed new and unique approaches for conducting immunization clinics. The goal of these outreach projects was to reach children not fully immunized, with a priority on administration of the fourth DTaP.

The Vaccine Advisory Committee for Colorado (VACC) continued to examine barriers to childhood immunizations. The committee's mission is to ensure that every Colorado parent who wants his or her child fully immunized will experience no financial or structural barriers. The VACC includes broad representation from key stakeholders in the fields of public health, school health, child advocacy, health care, philanthropy, and academia; it continues to be co-chaired by Lieutenant Governor Barbara O'Brien. The VACC functions to aggressively pursue the overall goal of Colorado being among the top-ranked states for childhood immunization through activities produced by five subcommittees appointed by a Steering Committee: Immunization Best Practices, CIIS Registry, Innovative Health Programs, Special Projects, and Public Awareness and Education.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Moved the Colorado Immunization Information System (CIIS) from the University of Colorado to the Colorado Immunization Program at the Colorado Department of Public Health and Environment				X
2. Expanded the Colorado Immunization Information System (CIIS) to include vaccinations for all ages				X
3. Improved the infrastructure for administering and tracking immunizations through new state funding to public health immunization clinics	X	X	X	
4. Continued to reduce barriers to childhood immunizations by carrying out the Vaccine Advisory Committee for Colorado's work plan	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is for 80.0 percent.

The Vaccine Advisory Committee for Colorado (VACC) continues to carry out the established work plan activities related to: Immunization Best Practices, CIIS Registry, Innovative Health Programs, Special Projects, and Public Awareness and Education. Additional funds were provided to local public health agencies to increase vaccine coverage through strategically located vaccine clinics offering both seasonal and H1N1 vaccines to children and later to their families, often in the school setting.

While the H1N1 Influenza Pandemic created additional demands on the public health infrastructure, state and local public health agencies used the opportunity to emphasize the importance of both the Seasonal Influenza vaccine and the H1N1 vaccine for children, youth and pregnant women. Colorado's 2009/2010 seasonal influenza vaccine rate for children ages 6 months through 17 years was 42.9, which compared with the national rate of 40. The 2009-10 H1N1 vaccine rate for children ages 6 months through 17 years was 35.2 which met the national average of 35.1

The H1N1 Pandemic also provided an opportunity for enhanced collaboration between the state health department and local public health, schools and child care facilities. One result was the development of a detailed disease surveillance program in schools.

c. Plan for the Coming Year
The target for reporting year 2011 is for 80.0 percent of 19 to 35 month olds to receive the full schedule of appropriate immunizations.

Activities will continue from the previous year including enhancing local partnerships between local public health, schools and child care facilities. The activities include: monitoring completed immunization certificates for required immunizations; provision of community-based vaccine clinics; and provision of educational information related to the efficacy of childhood vaccine.

State and local public health agencies will continue to provide the updated immunization information to providers, staff, and parents.

In collaboration with the Colorado Immunization Information System (CIIS) staff, public health will continue to engage providers to utilize the CIIS registry system. As of December 2009, 56.7 percent of potential vaccine providers in Colorado are linked with the CIIS. The goal for Colorado is 100.0 percent.

The Vaccine Advisory Committee for Colorado (VACC) will continue with their work plan activities related to: Immunization Best Practices, CIIS Registry, Innovative Health Programs, Special Projects, and Public Awareness and Education.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	24	23.5	23	22	21.5
Annual Indicator	24.8	23.8	23.7	22.1	21.4
Numerator	2357	2281	2312	2200	2142
Denominator	94969	96001	97617	99489	100252
Data Source				Birth Certificates	Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	21	21	20.5	20.5	20

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 births. This data is provided in the Colorado Births and Deaths document available at http://www.cdphe.state.co.us/hs/mchdata/mchdata.html.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 births. This data is provided in the Colorado Births and Deaths document available at http://www.cdphe.state.co.us/hs/mchdata/mchdata.html.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

a. Last Year's Accomplishments
The target for reporting year 2009 was 21.5 and 21.4 was achieved. The target was met. In 2009, 2,142 live births occurred among 100,252 females aged 15 through 17 years of age.

Colorado engages in a range of activities that influence the birth rate among youth and adults.

There was a 15 percent increase between 2008 and 2009 in the number of people seen in Title X family planning clinics with 60,739 men and women receiving care.

The Women's Health Unit worked closely with the Colorado Department of Health Care Policy and Financing (HCPF) to respond to questions from the Centers for Medicare and Medicaid Services (CMS) regarding the Colorado Reproductive Health Waiver (Medicaid 1115 Family Planning Waiver). The waiver expands family planning services to men and women 19-50 years old with incomes up to 200 percent of the Federal Poverty Level (FPL).

The state Family Planning Program received substantial funding from a private foundation to expand clinical services and provide long-term efficacious contraceptives to men and women through the Colorado Family Planning Initiative (CFPI). This initiative includes outreach to teens with the goal of decreasing unintended pregnancies in Colorado. CFPI funding will also support the Colorado Reproductive Health Waiver once approved.

The Adolescent Sexual Health workgroup was initiated to develop joint strategies and increase collaboration in this area. A team from Colorado participated in the "Moving from Interest to Action Initiative" sponsored by the Association of Maternal and Child Health Programs and the National Association of City and County Health Officers to address teen pregnancy and/or teen HIV/STI infection at the local level.

The Colorado legislature passed House Bill 1292 that established standards for local school districts to use when developing comprehensive and medically accurate sex-education curricula. The Colorado Organization for Adolescent Pregnancy, Parenting, and Prevention (COAPPP) was awarded a two-year grant to provide teen pregnancy prevention health education through school-based health centers at three high-risk schools.

Colorado did not reapply for federal funding for the Title V, Section 510 Abstinence Education Program and the program was discontinued.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increased the number of people seen in Title X family planning clinics	X			
2. Responded to questions from Centers for Medicare and Medicaid Services regarding the Colorado Medicaid 1115 Family Planning Waiver			X	
3. Developed the Adolescent Sexual Health Coordination Team				X
4. Participated in the Moving from Interest to Action Initiative sponsored by Association of Maternal and Child Health Programs and National Association of City and County Health			X	X
5. Passed a bill that established standards for local school districts to use when developing comprehensive and medically accurate sex-education curricula				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2010 is 21.0.

The Family Planning Program continued to receive funding from a private foundation to expand clinical services and provide long-term efficacious contraceptives to men and women through the CFPI. This initiative includes outreach to teens with the goal of decreasing unintended pregnancies in Colorado. Twenty agencies continue to successfully implement expansion grants awarded in January 2009. The Family Planning Program is also using Title X expansion dollars to support four new provider sites.

The Women's Health Unit, in collaboration with HCPF, formed a Medicaid Waiver Advisory Committee of providers and interested stakeholders that provides guidance on making implementation and participation in the Colorado Reproductive Health Waiver as simple and efficient as possible for providers and clients. Additionally, staff responded to a second set of questions from CMS regarding the waiver.

c. Plan for the Coming Year
The target for reporting year 2011 is 21.0.

The Women's Health Unit will work closely with HCPF if the Colorado Reproductive Health Waiver is approved to develop and carry out the implementation work plan to increase the number of women and men served in the state.

The Family Planning Program will continue expanding services through Title X and the CFPI. Social marketing approaches to address teen and unintended pregnancy will be used.

Women's Health staff members will remain active in HealthyWomen HealthyBabies, a coalition working to improve birth outcomes in Colorado. Work is underway to enhance access to preconception health information for women of childbearing age as a strategy to improve birth outcomes. Many aspects of preconception care are relevant to promoting healthy lifestyles for teens and preventing teen pregnancies. Additionally, staff members participate in a reproductive health workgroup focused on enhancing collaboration among providers and strategies to increase access to family planning services.

COAPPP and The National Campaign are sponsoring a statewide conference in October 2010 entitled "Raising the Bar: Putting the Promise to Practice in Adolescent Reproductive Health and Support for Young Families." The conference will include sessions on policy, advocacy, science-based program development and evaluation, sustainability, youth and community development, and health access & delivery. Participation is expected from clinicians, youth development professionals, health educators, and advocates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	35.5	35.5	36	36	38
Annual Indicator	35.2	29.3	35	35	35
Numerator					
Denominator					
Data Source				2006-2007 CO	2006-2007 CO

				Basic Screening Survey	Basic Screening Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38	40	40	42	42

Notes - 2009
Data reported for 2009 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders. The data repeat the data reported for 2007 since the survey is conducted every three years. That next survey will start in fall 2010.

Notes - 2008
Data reported for 2008 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders. The data repeat the data reported for 2007 since the survey is conducted every three years. That last survey was conducted in 2006-2007 and the next survey should be conducted in 2009-2010.

Notes - 2007
Data reported for 2007 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders.

a. Last Year's Accomplishments
The target for reporting year 2009 was 38.0 percent and 35.0 percent was achieved. The target was not met. The annual indicator showed that 35.0 percent of third grade children received protective sealants on at least one permanent molar tooth.

The Oral Health Unit worked with other funders of sealant programs and providers of these programs to use geographic information system mapping. This information was used to define service areas and explore potential areas for expansion. From September 2008 to May 2009, 28 percent of schools eligible for sealant programs received services. These schools are in densely populated areas such as the Denver area and Colorado Springs.

There is little reported data on referrals from school sealant programs that result in dental visits. Providers report that a difficulty in tracking this factor is the loss to follow-up care caused by the transient nature of participants in the sealant program. Some schools in inner city Denver have nearly 100 percent turnover of the classroom in a single school year, resulting in an inability to check for follow-up among the initial group of students. To better monitor this performance measure, the Oral Health Unit requested that the state's Medicaid agency gather information on the children seen in school sealant programs and then received a subsequent dental visit as defined by procedure codes billed to Medicaid. The Oral Health Unit negotiated the sharing agreement with Colorado Department of Health Care Policy and Financing, collected provider Medicaid numbers, and requested the first run of data.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Used geographic information system mapping information to better define service areas and explore potential areas for sealant program expansion				X
2. Requested additional data from the state Medicaid agency to track children seen in school sealant programs and who then received a subsequent dental visit as defined by procedure codes				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 38.0 percent.

Fourteen contracts were issued for a range of program activities including planning, implementation, and data collection. Ten contractors provide a fully implemented program; two contractors are conducting data collection with program implementation funding coming from other sources, and two planning grants have been awarded with an anticipated implementation date of September, 2010. The Oral Health Unit continues to work to ensure the fidelity of the program model, data accuracy, and other technical issues. Quarterly sealant meetings engage all grantees networking and information sharing, while individualized technical assistance and training on the use of Sealant Efficiency Assessment for Locals and States (SEALS) data entry and reporting.

c. Plan for the Coming Year
The target for reporting year 2011 is 40.0 percent.

Activities described above will continue.

The Oral Health Unit will involve selected communities in the active recruitment of providers to develop sealant programs using the GIS information referenced earlier. Priority will be given to the areas with the greatest unmet needs and expansion will be funded using other funds such as a Health Services and Resources Administration grant.

The Oral Health Unit will conduct the semi-annual (every three-year) data collection project to determine state-wide prevalence of dental sealants and other measure of oral health status.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	3	3	3	3	2.5
Annual Indicator	3.4	3.2	3.2	2.7	2.6

Numerator	33	32	32	28	27
Denominator	970051	989454	1002764	1019648	1036835
Data Source				Death certificates	Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.4	2.4	2.3	2.3	2.2

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 data representing deaths from all motor vehicle injuries for children from birth through age 14. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data representing deaths from all motor vehicle injuries for children from birth through age 14. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

a. Last Year's Accomplishments
The target rate for reporting year 2009 was 2.5 deaths per 100,000 children. The target was not met with a rate of 2.6 deaths per 100,000 children. There were 27 deaths to children ages 14 years and younger caused by motor vehicle crashes.

The Injury Community Planning Group (ICPG) made a recommendation to the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) to add restraint use as a required element in MATRIX (the EMS data collection system). Having restraint use data collected consistently statewide would enable the ICPG to evaluate prevention projects by looking at restraint use in areas that have prevention programs and examining how restraint use impacts injury severity. Restraint use data also influences direct patient care treatment, potential legislation, trauma system improvements, injury pattern recognition, the review of financial and health impacts, and future safety mechanisms for vehicles. The ICPG worked with the Colorado Department of Public Health and Environment (CDPHE) EMS program to encourage EMS agencies and hospitals to apply for injury prevention projects under the EMS Provider Grant program. Motor vehicle crash prevention projects have been funded by the program.

The Injury, Suicide and Violence Prevention (ISVP) Unit continued to support local communities by providing and coordinating technical assistance and developing other resources. Four fact sheets on childhood injury topics, including motor vehicle safety, were developed for distribution through local child passenger safety coalitions. These fact sheets are posted at www.coinjuryprevention.org.

The Colorado Department of Transportation (CDOT) created a social marketing campaign targeting Hispanic parents. Materials were distributed through several grassroots community coalitions funded by CDOT to improve child passenger safety among children who are Hispanic.

The ISVP Unit worked with the Department of Human Services (DHS) to pass a rule that strengthens child care center regulations by including updated child passenger safety (CPS) statute information and requiring child care centers to include the Family Transportation Agreement in their parent handbooks.

ISVP staff continued to serve on the state Child Passenger Safety Advisory Board.

The ISVP Unit hosted a Colorado Child and Adolescent Motor Vehicle Safety Symposium for state and local partners addressing teen motor vehicle safety issues. This one-day symposium brought 140 members of the motor vehicle safety community together to share their successes in reducing road traffic injures and ideas about how to continue to improve the motor vehicle safety of children and adolescents in Colorado. During the Symposium 40 CPS technicians received continuing education credit for attending special sessions on CPS topics.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Added restraint use as a required element in the EMS data collection system				X
2. Encouraged Emergency Medical Services (EMS) agencies and hospitals to apply for injury prevention projects under the EMS Provider Grant program			X	
3. Developed four fact sheets on childhood injury topics, including motor vehicle safety, for distribution through local child passenger safety coalitions		X	X	
4. Participated in the creation of a social marketing campaign targeting Hispanic parents			X	
5. Worked with the Department of Human Services (DHS) to pass a rule that requires child care centers to include the Family Transportation Agreement in their parent handbooks				X
6. Served on the state Child Passenger Safety Advisory Board				X
7. Hosted a Colorado Child and Adolescent Motor Vehicle Safety Symposium for state and local partners addressing teen motor vehicle safety issues		X	X	
8.				
9.				
10.				

b. Current Activities
The target rate for reporting year 2010 is 2.4 per 100,000.

The ISVP Unit received a two-year grant to create a Child Injury Prevention Policy Plan that includes strategies to enhance Colorado's booster seat law to require that children be secured in booster seats through age eight, or until they are at least four feet nine inches tall. The ISVP Unit formed a new Child Injury Policy Subgroup (CIPS) of the ICPG to oversee the development, implementation and evaluation of the Policy Plan. In order to develop the Policy Plan, CIPS members conducted a systematic review of existing best practice policy recommendations and booster seat laws from other states and completed a child passenger safety stakeholder analysis. The Policy Plan was completed in June 2010 and was introduced to teen driving safety partners at a statewide Injury, Suicide and Violence Prevention Conference in August 2010.

ISVP staff prepared bill analyses for decision makers within CDPHE for different versions of Senate Bill 10-110, which started out as primary enforcement bill for adult seatbelts, but then

became a child passenger safety bill. The CIPS also developed a fact sheet on evidence-based booster seat policies to inform stakeholders and policymakers. The law strengthened Colorado's booster seat law by requiring children ages four through seven to be properly restrained.

The CDPHE partnered with the CDOT to create a new data system that links hospital discharge, trauma registry, EMS and other data.

c. Plan for the Coming Year
The target rate for reporting year 2011 is 2.4 per 100,000.

The ISVP Unit and the ICPG will continue to promote seatbelt use for all occupants of motor vehicles and will monitor any seatbelt or CPS legislation, if proposed, for the 2011 legislative session.

ISVP staff will continue to serve as a board member on the State CPS Advisory Board.

The Colorado Child Fatality Prevention State Review Team will conduct comprehensive reviews of motor vehicle death cases that involve children ages 0-14. The team will identify strategies to prevent child motor vehicle deaths and will make recommendations to the Colorado General Assembly in their Annual Legislative Report.

The Alliance will implement the strategies outlined in the Child Injury Prevention Policy Plan to educate the public about the importance of the graduated drivers licensing law.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		42	47	43	50
Annual Indicator	41.5	46.3	42	48.2	59.5
Numerator					
Denominator					
Data Source				2007 National Immunization Survey	2008 National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	60	60	60

Notes - 2009
Data shown for reporting year 2009 are breastfeeding data collected by the National Immunization Survey for infants born in 2006 (see

http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The percentage is provisional.

Notes - 2008
Data shown for reporting year 2008 are breastfeeding rates collected by the National Immunization Survey for infants born in 2005 (see http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The rate is provisional.

A target of 50 percent is shown for all years, consistent with the Healthy People 2010 goal for breastfeeding at six months.

Notes - 2007
Data shown for 2007 are breastfeeding data collected by the National Immunization Survey for infants born in 2004. This method represents a change from the methodology of previous NIS surveys, where the data pertained to the year the interview occurred -- which was not necessarily the birth year of the infant.

a. Last Year's Accomplishments
The target for reporting year 2009 was 50.0 percent and 59.5 was achieved. The target was met.

The annual indicator showed that 59.5 percent of mothers breastfed their infants at 6 months of age. Additionally, breastfeeding duration rates for mothers participating on the WIC Program increased in 2009: duration rates at 6 months increased from 28.1 percent in 2008 to 29.6 percent in 2009. WIC breastfeeding rates at 12 months also increased from 16.1 percent in 2008 to 18.9 percent rate in 2009.

The Colorado WIC Program, Colorado Physical Activity and Nutrition Program (COPAN), and the Colorado Breastfeeding Coalition worked together to strengthen hospital practices, workplace support, and messaging about and supporting of exclusive breastfeeding. These efforts have the potential to impact breastfeeding duration.

COPAN contracted with Marianne Neifert, a pediatrician and lactation expert, to meet with 25 hospitals and communities regarding the Colorado Can Do 5! Initiative. The initiative involves providing evidence-based research, training, and technical assistance to hospitals to encourage them to adopt the five practices found to significantly impact breastfeeding continuation. The practices are 1) The infant is breastfed in the first hour after birth; 2) The infant is fed only breast milk in the hospital; 3) The infant stays in the same room with the mother in the hospital; 4) The infant does not use a pacifier in the hospital and; 5) Hospital staff gives the mother a telephone number to call for help with breastfeeding after discharged from the hospital. Hospitals received presentations tailored for each venue, audience, and specific needs.

Data comparison between 2002 and 2008 show significant improvements in these hospital practices supportive of breastfeeding with the exception of pacifier use (i.e., pacifier use increased).

The Colorado Breastfeeding Coalition acquired funds, secured a videographer, and wrote a plan for the production of three videos on working and breastfeeding. The videos were designed to motivate, educate, and inspire mothers to keep breastfeeding after returning to work. The videos also provide employers with information about how to comply with the Colorado Workplace Accommodation for Nursing Mothers law.

The Colorado WIC Program changed its food packages on June 1, 2009 to better meet the nutritional needs of WIC participants including aligning with the American Academy of Pediatrics infant feeding guidelines of promoting exclusive breastfeeding for the first six months of life.

WIC program personnel were provided with stronger messages on why and how to support mothers with exclusive breastfeeding and building a good milk supply, particularly in the first month postpartum. Since the change in food packages, Colorado WIC experienced an increase in the number of exclusively breastfed infants enrolled in the Program, as well as a decrease in the amount of formula issued to breastfed infants.

Colorado used multiple methods to educate employers and mothers about the Colorado Workplace Accommodation for Nursing Mothers law. The Breastfeeding Coalition produced a series of three YouTube videos to take advantage of the power and reach of social media to touch new mothers and employers. Located at www.YouTube.com/user/cobfcvideos, the videos are Breastfeeding and Working - An Overview; Employer Perspective on Accommodating Nursing Employees; and Colorado's Workplace Accommodations for Nursing Mothers Act. A Spanish language video was also produced. At the YouTube site, visitors have access to additional resources and links for more information about workplace lactation. There were more than 2,000 views of the videos during the first month's posting on YouTube.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked collaboratively to strengthen hospital practices, workplace support, and messaging about and supporting of exclusive breastfeeding				X
2. Contracted with Marianne Neifert, a pediatrician and lactation expert, to meet with 25 hospitals and communities regarding the Colorado Can Do 5! Initiative				X
3. Acquired funds, secured a videographer, and wrote a plan for the production of three videos on working and breastfeeding		X		
4. Changed the WIC food packages on June 1, 2009 to better align with the American Academy of Pediatrics infant feeding guidelines of promoting exclusive breastfeeding for the first six months of life	X	X	X	X
5. Provided WIC staff with messages on why and how to support mothers with exclusive breastfeeding and building a good milk supply, particularly in the first month postpartum	X	X		
6. Educated employers and mothers about the Colorado Workplace Accommodation for Nursing Mothers law	X	X	X	
7.				
8.				
9.				
10.				

b. Current Activities
The 2010 target is 60.0 percent.

The Breastfeeding Coalition received a grant to participate in the Business Case for Breastfeeding project. Thirty individuals from around the state participated in a train-the-trainer event. Since February at least 100 people have been trained as business outreach workers in four regions of the state. Over 30 businesses participated in two webinars. Also, a variety of resources were developed for employers, mothers and health care providers. The grant ended in August, but the coalition will continue as a resource for employers in the coming years.

COPAN contracted with Marianne Neifert, MD to provide three final presentations about the

Colorado Can Do 5! Initiative. Presently, all Colorado hospitals with maternity services and approximately 1,000 health care professionals have received the information on the five hospital supportive practices for breastfeeding duration.

The Colorado WIC Program funded and trained seven additional WIC agencies to implement breastfeeding peer counseling programs. There are now peer counseling programs in 12 agencies serving 86 percent of the program's participation.

The WIC Program increased the lactation expertise in nearly all of the WIC agencies through Lactation Management Specialist (LMS) training.

In an effort to simplify access to breastfeeding information on the state health department website, a breastfeeding specific site was created that provides breastfeeding and other resources.

c. Plan for the Coming Year
The target for reporting year 2011 is 60.0 percent.

Since all Colorado hospitals with maternity services are familiar with the Colorado Can Do 5! Initiative, an award and recognition program will be developed. The awards will recognize institutions that use the five hospital practices supportive of breastfeeding. The application process will include a hospital survey regarding implementation of policies and procedures and a survey of mothers who have delivered at the hospital. Awards will be issued by the end of the year and an article will be released to the press celebrating the efforts of these select hospitals.

An award process will also be developed for the Colorado Business Case for Breastfeeding project. During the summer, Colorado employers will be invited to apply for an award and recognition of their support of nursing employees in the workplace.

The WIC Program will continue to reach out to mothers to support their efforts to breastfeed longer and exclusively. Local agencies without existing programs will be encouraged to apply for the Breastfeeding Peer Counselor program. During the statewide WIC conference, WIC staff will participate in sessions on eliminating breastfeeding disparities for African American families and promoting and extending exclusive breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.5	97.5	97.6	97.2	97.8
Numerator	66769	66912	68282	68088	67905
Denominator	68475	68660	69939	70082	69432
Data Source				Newborn Hearing Screening Program	Newborn Hearing Screening Program

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	98

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 data.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

The numerator is the number of newborns that underwent the newborn hearing screening at birth who were born to Colorado residents who delivered in Colorado. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out-of-state.)

a. Last Year's Accomplishments
The target for reporting year 2009 was 98.0 percent and 97.8 percent was achieved. The target was not met. A total of 67,905 newborns were screened for hearing before hospital discharge.

A customized tool entitled the Roadmap for Families was developed by Colorado Hands & Voices. It is designed according to each hospital's referral and follow-up protocol and is filled out to address each families needs when an infant fails the newborn hearing screen needs. (attachment) Local Early Hearing Detection and Intervention (EHDI) teams were convened to assist with the development of protocols for follow-up and to identify appropriate referral.

EHDI teams consisted of the local Audiology Regional Coordinator, Hands & Voices parent guide, hospital coordinator, Colorado Hearing Resource Coordinator, Early Intervention (Part C) Colorado, Health Care Program for Children with Special Needs (HCP) nurse, physicians and any other stakeholders. The Roadmap for Families was completed for 40 out of the 54 hospitals. Data is being analyzed to determine if this tool has improved timely and appropriate follow-up.

The Integrated Database System (CHIRP/NEST) has successfully been converted to a web based application.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed a customizable tool for families called the Roadmap for Families and used it in 40 hospitals	X	X		
2. Converted the Integrated Database System (CHIRP/NEST) to a web based application				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 98.0 percent.

Certain responsibilities and duties of the newborn metabolic screening follow-up coordinator and the newborn hearing screening follow-up coordinator (a vacant position) are being reapportioned to maximize efficiency and to ensure optimal use of resources. Job duties are being reassessed and a new job description is being created prior to hiring for the position, which will be accomplished by September.

The Colorado Infant Hearing Advisory Committee is completing the revisions of the Colorado Infant Hearing Guidelines to meet the Joint Committee on Infant Hearing recommendations. The Guidelines serve as best practices for hospitals and providers serving families and their children with hearing loss.

Training for the hospital coordinators and audiologists will take place in the summer. The trainings will focus on ways to increase efficiencies in data management; improve the follow-up for infants who fail or miss a screen through real time data entry; and decrease paperwork.

The Roadmaps for Families tool will be integrated into the final remaining fourteen hospitals within the state.

c. Plan for the Coming Year
The target for reporting year 2011 is 98.0 percent.

Otoacoustic emissions hearing screening equipment will be available for use by both lay and nurse midwives. This will increase the proportion of infants born at home that receive a hearing screen. Training is planned for the spring.

The EHDI Program is working with the immunization registry staff to investigate linking the newborn hearing and newborn metabolic results to the immunization registry. This will give primary care providers the results of the screens electronically. Giving access to the results will assist the providers in helping families with recommended follow-up and enhance the medical home approach.

The Assuring Better Child Development (ABCD) screening program has helped providers use a standardized screening tool. As the program is expanded statewide, there will be efforts to integrate this screening with the newborn screening program. This effort will result in more efficiencies that lead to timely and appropriate follow-up for all children who do not pass a hearing, metabolic or developmental screen.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	10	9	10	8
Annual Indicator	12.6	11.9	10.3	8.2	8.7
Numerator					
Denominator					
Data Source				Colorado Child Health Survey	Colorado Child Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	7	7	6	6

Notes - 2009
Data shown for reporting year 2009 are calendar year 2009 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2008 Colorado Child Health Survey Data. The percentage includes children age 1-14 uninsured at the time of the survey.

Notes - 2007
Data shown for 2007 are calendar year 2007 Colorado Child Health Survey data. The percentage includes children age 1-14 uninsured at the time of the survey.

a. Last Year's Accomplishments
The target for reporting year 2009 was 8.0 percent and 8.7 percent was achieved. The target was not met. The annual indicator showed that 8.7 percent of children had no health insurance.

The MCH Access to Care Workgroup developed a summary of the access to care issues and challenges experienced by local health departments who serve MCH populations. The workgroup then examined the access to care efforts of other community-based partners funded by Colorado-based private foundations. Specifically, the workgroup reviewed The Colorado Trust's Early Childhood Health Integration Initiative to fund local early childhood councils to incorporate health into their local early childhood systems building efforts. The workgroup also reviewed the

Colorado Health Foundation's Increasing Access to Care Initiative that supports family resource centers in local communities to increase outreach and enrollment in public health insurance programs.

The MCH Access to Care Workgroup formed an evaluation subcommittee to explore the efficacy of local public health efforts to facilitate enrollment of children into Medicaid.

The Women's Health Unit initiated a Local Health Agency and Medicaid Workgroup to facilitate communication and improve the partnership between local public health agencies and the Department of Health Care Policy and Financing (HCPF). The goal was to improve access to adequate and early care for pregnant women, as well as services to children and youth 19 and younger enrolled in Medicaid. The workgroup met monthly from May to August 2009. The workgroup was discontinued when it was determined that the goal of the group was being addressed through broader external stakeholder groups, such as the Covering Kids and Families Agency Partners Workgroup, which addresses enrollment issues for pregnant women and children receiving Medicaid or Child Health Plan Plus benefits and the HealthyWomen HealthyBabies Access to Care Workgroup, which addresses system capacity and coordination issues for low-income pregnant women. Additionally, other needs initially identified by the group had been met, including concerns around communication and consistency between Medicaid and local public health agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed a summary of the access to care issues and challenges experienced by local health departments who serve MCH populations				X
2. Formed an evaluation subcommittee to explore the efficacy of local public health efforts to facilitate enrollment of children into Medicaid				X
3. Initiated a Local Health Agency and Medicaid Workgroup to facilitate communication and improve the partnership between local health agencies and the state Medicaid program				X
4. Passed the Colorado Healthcare Affordability Act to increase access to Medicaid and CHP+				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The 2010 target is 8.0 percent.

The Colorado Healthcare Affordability Act created a hospital provider fee that will generate an estimated $600 million in revenue. This revenue will be matched by the federal government for a total of $1.2 billion that will help reimburse providers for uncompensated care and will allow Colorado to expand Medicaid to parents and single adults up to 100 percent of the federal poverty level, to expand Child Health Plan Plus to children up to 250 percent of federal poverty level, to create a Medicaid buy-in program for the disabled community up to 450 percent of the federal poverty level, and to institute continuous 12-month enrollment. A thirteen member

Oversight and Advisory Committee is responsible for working with the Department of Health Care Policy and Financing to implement this act.

The Unit provides technical assistance to local early childhood councils. Fifteen of the twenty grantees are focused on increasing access to preventive oral and medical health care. Implementation strategies include but are not limited to: increasing the number of health care providers who accept Medicaid and/or CHP+; reducing local transportation barriers; and promoting the co-location/integration of oral health services with primary health care. The Early Childhood Health Integration Initiative works with the Colorado Children's Healthcare Access Program to assure that the technical assistance provided to health care practices by both programs is complementary.

c. Plan for the Coming Year
The target for reporting year 2011 is 7.0 percent.

The MCH Access to Care Workgroup will continue to examine the role of state and local MCH in access to care activities and will implement recommendations based on the evaluation subcommittee's survey findings and the 2010 MCH needs assessment results.

The Child, Adolescent and School Health Unit will continue to provide technical assistance to the local early childhood councils who are funded through the Early Childhood Health Integration Initiative, as many grantees are focused on increasing access to care.

The MCH Program anticipates that health care reform will directly and indirectly influence this national performance measure, although the scope of impact is not yet known. An example of this potential impact includes additional funding that will become available to local school-based health centers as a result of health care reform. While the state-level Colorado School-Based Health Center Program will not receive funds, local school-based health centers will be eligible to apply directly for federal support. In the upcoming year, the MCH Program will continue to support the local infrastructure of school-based health centers through the provision of technical assistance, as well as through the administration of state general fund dollars to fund approximately 40 school-based health centers statewide.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		24	24	24	23
Annual Indicator	24.2	24.7	24.3	24.3	23.5
Numerator	8739	8832	9018	9825	12139
Denominator	36113	35758	37111	40432	51659
Data Source				2007 Pediatric Nutrition Surveillance	2009 Pediatric Nutrition Surveillance
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer					

than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	23	23	23	23	23

Notes - 2009
Data shown for 2009 are from the 2009 Pediatric Nutrition Survey. This can be accessed on the WIC website at: http://www.cdphe.co.us/ps/wic/nutritionsurveillance/nutritionsurveillance.html.

Notes - 2008
Data shown for 2008 are from the 2007 Pediatric Nutrition Survey. This can be accessed on the WIC website at: http://www.cdphe.co.us/ps/wic/nutritionsurveillance/nutritionsurveillance.html.

Notes - 2007
Data shown for 2007 are from the 2006 Pediatric Nutrition Survey.

a. Last Year's Accomplishments
The target for reporting year 2009 was 23.0 percent and 23.5 percent was achieved. The target was not met. A total of 12,139 children ages 2 to 5 years out of 51,659 who receive WIC services had a Body Mass Index at or above the 85th percentile.

The Colorado WIC Program developed and launched an annual nutrition education planning process for local agencies. Each local WIC agency received assistance from the state office to develop and implement community-specific action plans targeting the prevention of overweight and breastfeeding promotion. The nutrition education planning process included: conducting a needs assessment; developing an action plan with evaluation; and report requirements. Plans were implemented between October 1, 2008 and September 30, 2009.

Colorado implemented USDA's interim food package rule on June 1, 2009. WIC food package changes include: the addition of fresh fruits and vegetables; reduction in the amount of juice given to children and no juice to infants; reduction of saturated fat; and the inclusion of whole grains. These positive changes better align with WIC's nutrition education messages.

Colorado WIC teamed with the Women's Health Unit to host the National Maternal Nutrition Intensive Course videoconference from the University of Minnesota. Both state and local level WIC Nutritionists attended this conference. Approximately 20 state and local level WIC Nutritionists attended this conference.

State WIC Program staff continued to collaborate with COPAN, Women's Health and the CDPHE Early Childhood Task Force to provide technical assistance to communities who are implementing early childhood obesity prevention strategies.

Three articles were included in the Colorado WIC News about overweight prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Developed and launched an annual nutrition education planning process for local agencies			X	
2. Implemented USDA's interim food package rule on June 1, 2009	X			

3. Hosted the National Maternal Nutrition Intensive Course videoconference from the University of Minnesota		X	X	
4. Provided technical assistance to communities who are implementing early childhood obesity prevention strategies		X	X	
5. Included three articles in the Colorado WIC News about overweight prevention			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 23.0 percent.

The nutrition education planning process continued and the state office reviewed the evaluation of current activities and the next year's plan. Prevention of overweight continued to be a health outcome goal required of every plan.

Planning is underway to enhance WIC staffs' comfort with and expertise in addressing weight-related issues with participants. An action plan is under development that will require state and local agency collaboration to carry out activities.

The Colorado WIC Nutrition Unit teamed with the Women's Health Unit to again host the National Maternal Nutrition Intensive Course videoconference from the University of Minnesota.

State WIC Program, COPAN, Women's Health and the CDPHE Early Childhood Task Force staff worked together to develop and deliver consistent messages regarding childhood overweight prevention. These groups participated in a strategic planning process for a statewide early childhood obesity prevention plan.
A significant increase in federal dollars allows Colorado WIC to expand its Breastfeeding Peer Counselor Program from five to twelve local agencies. See National Performance Measure 11 for more information.

Three issues of the Colorado WIC News included information relevant to overweight prevention.

c. Plan for the Coming Year
The target for reporting year 2011 is 23.0 percent.

Activities will continue from the previous year.

The Colorado WIC State Meeting is planned for October 2010. The meeting's primary theme is on weight management for women and children with a secondary theme of health disparities and improving cultural competence.

Significant resources continue to devote to the design and testing phases of Compass, Colorado WIC's new computer system that is scheduled for rollout in 2011. Compass will provide staff with tools (i.e. automated growth charts and an interview process that promotes participant-centered care) to better assess and counsel participants who are overweight or at risk of becoming overweight.

The early childhood obesity prevention group will finalize and begin implementing their strategic plan.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		10	9	10	10
Annual Indicator	10.4	10.2	10.4	10.8	8.1
Numerator					
Denominator					
Data Source				Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	7.9	7.9	7.8

Notes - 2009
Data for reporting year 2009 are from 2008 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2008
Data for reporting year 2008 are from 2007 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2007
Data for reporting year 2007 are from 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

a. Last Year's Accomplishments
The target for reporting year 2009 was 10.0 percent and 8.1 percent was achieved. The target was met.

The annual indicator for reporting year 2009 (using 2008 data) showed that 8.1 percent of women smoked in the last three months of pregnancy. The rate decreased from 10.8 percent the previous year. Recent tax increases and the Colorado Clean Indoor Air Act banning public smoking likely contributed to decreased smoking by women before, during and after pregnancy. Six of 14 community-level MCH plans incorporated prenatal smoking cessation messages. The Healthy Baby Campaign Action Guide and resources were expanded to include a prenatal smoking cessation message. Resources were available from the Women's Health and Healthy Baby campaign websites (www.healthy-baby.org). Seventy-three Colorado agencies requested

materials from the website.

The Colorado Health Foundation (CHF) funded the Baby & Me Tobacco Free program. The program provided vouchers for free diapers to low-income women who completed smoking cessation classes and who participated in carbon dioxide monitoring during pregnancy and up to one year postpartum. The program uses community-based facilitators to do tobacco cessation counseling with pregnant women. The women who quit are eligible to receive vouchers for diapers each month they remain smoke free postpartum, up to a year after the birth of their baby. The program was expanded from 18 to 32 counties in Colorado, primarily rural. Partners are community clinics and health departments, with the program being offered as a part of Prenatal Plus, WIC, and other programs that serve pregnant women.

The Colorado Clinical Guidelines Collaborative (CCGC), Women's Health Unit and State Tobacco Education and Prevention Partnership (STEPP) staff continued drafting an evidence-based prenatal smoking cessation guideline. The prenatal smoking cessation guideline is a supplement to the general tobacco cessation guideline.

A division-wide prenatal smoking cessation project team convened monthly to address prenatal smoking cessation among WIC, STEPP, Prenatal Plus, Healthy Baby campaign and Nurse Home Visitor Programs. The team distributed a provider resource list to 342 Colorado agencies. A decision tree flow chart was developed for front line staff for use in counseling pregnant women about smoking cessation.

STEPP continued statewide media and website campaigns targeting adolescents (12-18 year olds) and young adults (19-25 year olds). A STEPP funded smoking cessation website (www.myquitpath.com) offered tips and tools to help smokers quit. The Colorado QuitLine provided telephone coaching services and free nicotine replacement therapy, with a doctor's prescription, to Colorado residents requesting the service. The Colorado Department of Health Care Policy and Financing (HCPF) expanded the Medicaid benefit for smoking cessation from one 90-day drug therapy per lifetime to two 90-day drug therapy treatments per year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued the Baby and Me Tobacco Free program	X	X		
2. Drafted an evidence-based prenatal smoking cessation guideline				X
3. Convened monthly a division-wide prenatal smoking cessation project team to address prenatal smoking cessation				X
4. Continued statewide STEPP media and website campaigns targeting adolescents and young adults			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 8.0 percent.

The CCGC, Women's Health Unit and State Tobacco Education and Prevention Partnership

staffs completed evidence-based prenatal smoking cessation clinical practice guidelines. CCGC and Women's Health staffs offered two webinars titled, Working with Pregnant Women Who Smoke? Tools You Can Use to Help Them Quit.

The Baby & Me Tobacco Free program was expanded from 32 to 42 counties in Colorado, primarily rural. Nearly 900 women have been enrolled in the program. Preliminary results show a quit rate of 60-68 percent.

The Department of Health Care Policy and Financing printed the Colorado QuitLine telephone number on all Medicaid cards. Newly enrolled Medicaid clients receive an introduction packet that includes prenatal smoking cessation and secondhand smoke messages. Presumptive eligibility clients receive a welcome letter with educational messages related to tobacco cessation and secondhand smoke. Health care professionals are updated about Medicaid tobacco cessation benefit changes.

The Colorado Department of Public Health and Environment (CDPHE) received American Recovery and Reinvestment Act (ARRA) funds to reduce smoking prevalence and exposure to secondhand smoke among low-income pregnant women and Medicaid populations. The QuitLine offers a prenatal protocol and has added a postpartum protocol.

c. Plan for the Coming Year
The target for reporting year 2011 is 8.0 percent.

Objectives of the ARRA grant include creating a statewide outreach/media campaign to direct pregnant and Medicaid smokers to the QuitLine, increase the number of successful quits, sustain those quits among pregnant women, and increase the number of Medicaid participants who use their Medicaid pharmacotherapy benefit.

ARRA funds will be used to expand the Fax-to-Quit program targeting Medicaid providers, OB/GYN providers serving the Medicaid population and community health centers serving the uninsured.

The Baby & Me Tobacco Free program is funded by the Colorado Health Foundation and Rocky Mountain Health Plans through October 2011. The program is expected to be offered in eleven additional front-range metropolitan areas.

The STEPP funded websites and social marketing activities will continue. The Healthy Baby campaign, Family Planning, Nurse Home Visitor, Prenatal Plus, and WIC programs continue promoting prenatal smoking cessation efforts to clients statewide.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	12	11.5	11	10.5	9.5
Annual Indicator	13.7	14.6	10.8	9.5	12.4
Numerator	47	51	38	34	45
Denominator	342486	348573	352852	358249	363012
Data Source				Death	Death

				certificates	certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.5	9	8.5	8	7.5

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 data representing suicide deaths for youth ages 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/. Since the suicide rate fluctuates annually, the annual performance objectives for 2010, 2011, 2012, and 2013 were not modified based on the annual indicator for reporting year 2009 (in response to the data alert). It is anticipated that the rate will decrease next year.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data representing suicide deaths for youth age 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

a. Last Year's Accomplishments
The target for reporting year 2009 was 9.5 per 100,000 and 12.4 per 100,000 was achieved. The target was not met. There were 45 suicide deaths among youths aged 15 through 19.

There were 45 suicide deaths among youth ages 15 through 19, and suicide remained the second leading cause of death among youth ages 10 through 24 in Colorado. Based on death certificate data from 1999-2008, the ten-year annual average suicide rate for young adults ages 15-19 in Colorado was 11.9 per 100,000, more than twice the Healthy People 2010 goal of 5.0 per 100,000 for all ages.

State funding of $283,000 was allocated for suicide prevention programs statewide. The Office of Suicide Prevention provided more than 15,000 pieces of public awareness materials regarding suicide and suicide prevention to individuals and organizations in every region of the state. The Office, in partnership with The Colorado Trust and Mental Health America of Colorado, wrote and released a new statewide strategic plan for suicide prevention and intervention entitled Preventing Suicide in Colorado: Progress Achieved and Goals for the Future. As part of the dissemination of the plan, Office staff traveled and presented at five regional kickoff and media events to promote the plan statewide. The Office also helped organize and sponsor the second annual Bridging the Divide: Suicide Awareness and Prevention Summit at Regis University, which was attended by 250 people.

The Office provided funding for suicide prevention efforts in five Colorado counties and at the University of Colorado at Boulder through a grant from the Substance Abuse and Mental Health Services Administration for state-sponsored youth suicide prevention and intervention. The project, entitled Project Safety Net, targeted youth in the juvenile justice and child welfare system by training adults who work in those systems to recognize and intervene with suicidal youth and refer them to services. Other activities included ensuring that the 1-800-273-TALK crisis hotline is

operational 24 hours per day, seven days per week; participating in the advisory board of the Colorado School Safety Resource Center and Safe2Tell, an anonymous tip line for Colorado students and parents to report violent or dangerous activities; and continuing to disseminate community grants dedicated to suicide prevention across the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided more than 15,000 pieces of public awareness materials regarding suicide and suicide prevention to individuals and organizations in every region of the state	X	X		X
2. Wrote and released a new statewide strategic plan for suicide prevention and intervention entitled Preventing Suicide in Colorado: Progress Achieved and Goals for the Future				X
3. Presented at five regional kickoff and media events to promote the plan statewide		X	X	
4. Organized and sponsored the second annual Bridging the Divide: Suicide Awareness and Prevention Summit at Regis University, which was attended by 250 people		X	X	
5. Provided funding for suicide prevention efforts in five Colorado counties and at the University of Colorado at Boulder	X	X		
6. Continued other activities within workplan to reduce suicide	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2010 is 9.5 deaths per 100,000.

State funding of $288,000 was allocated for suicide prevention programs statewide. Activities included planning and sponsoring the third annual Bridging the Divide: Suicide Awareness and Prevention Summit at Colorado State University in May 2010.

In October 2009, the Office of Suicide Prevention was awarded three additional years of funding from the Substance Abuse and Mental Health Services Administration to continue and expand Project Safety Net. Eight community agencies that serve twenty counties are training adults to recognize and intervene with suicidal youth, and to refer those youth to appropriate services. Project Safety Net is targeting adults who work with Hispanic and Latino(a) youth, lesbian, gay, bisexual, transgender and questioning youth, and youth in the juvenile justice and child welfare systems, all of which are at an elevated risk for suicide. Project Safety Net also includes a youth suicide prevention awareness campaign entitled Start the Conversation. Posters, stickers, informational brochures, and a thirty second radio spot have been disseminated statewide in English and Spanish.

Other activities accomplished include ensuring that the hotline is operational 24 hours per day, every day; disseminating community grants dedicated to suicide prevention across the state; working with the Suicide Prevention Coalition of Colorado; and participating on key advisory boards.

c. Plan for the Coming Year

The target for reporting year 2011 is 9.0 deaths per 100,000.

Activities will continue from the previous year.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	80	83	85	83
Annual Indicator	71.9	68.6	81.4	80.5	82.7
Numerator	639	619	725	749	767
Denominator	889	902	891	930	928
Data Source				Birth certificates	Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	88	90	90	90

Notes - 2009
Data shown for reporting year 2009 represent calendar year 2008 data. The denominator represents very low birth weight births to Colorado residents.

Notes - 2008
Data shown for reporting year 2008 represent calendar year 2007 data. The denominator represents very low birthweight births to Colorado residents.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

a. Last Year's Accomplishments
The target for reporting year 2009 was 83.0 percent and 82.7 percent was achieved. The target was not met. There were 767 very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

There were 767 very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Hospitals self-report their level of perinatal care to the Colorado Perinatal Care Council (CPCC). CPCC certifies hospitals' levels in accordance with the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) guidelines and assesses hospitals every three years. The guidelines increased the number of tiers designated as Level III. New designations took effect in January 2006. As of November 2006, 17 hospitals were Level III; eight were Level IIIA; seven were Level IIIB; and two were Level IIIC. Before the guideline change, eight hospitals were Level III.

The numbers reported in 2009 reflected an increase in the percent of very low birth weight infants

delivered at facilities for high-risk deliveries and neonates. This improvement can be attributed to former Level II hospitals upgrading to Level III as a result of the revised guideline, rather than referral pattern changes from Level II to Level III facilities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitored data associated with this measure				X
2. Participated in the Colorado Perinatal Care Council				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 85.0 percent.

The Colorado Perinatal Care Council (CPCC) consists of obstetric and neonatal providers in Colorado and most hospitals are represented on it. The Council's work focuses on hospital designation, yet the Council also addresses other perinatal issues of note. Current initiatives include elective deliveries without medical indication, central line associated bloodstream infections (CLABSI), promoting breastfeeding by encouraging hospitals to become "baby friendly," and addressing antenatal steroid use.

A Women's Health Unit staff person participates in the CPCC and engages in information sharing, interaction, and collaboration with other members.

c. Plan for the Coming Year
The target for reporting year 2011 is for 88.0 percent.

A Women's Health Unit staff member will continue to participate on CPCC. Staff will continue to monitor this measure.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	83	83	84	84	82
Annual Indicator	80.2	80.1	79.7	78.1	76.9
Numerator	53955	54147	55354	53828	52298
Denominator	67251	67639	69430	68957	67985

Data Source				Birth certificates	Birth certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	77	78	79	80	81

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 data. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/index.html.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/index.html.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. Number of pregnant women whose onset of prenatal care is unknown have been excluded.

a. Last Year's Accomplishments
The target for reporting year 2009 was 82.0 percent and 76.9 percent was achieved. The target was not met. This measure continues to decrease and the annual indicator for 2009 showed that 76.9 percent (data reported for 2008 births) of infants were born to pregnant women who received prenatal care beginning in the first trimester.

The Maternal and Child Health (MCH) program initiated an Access to Care State and Local Planning Workgroup. The workgroup's goal was to examine existing enabling service strategies and to build support for systems building and community mobilization activities. The workgroup looked at current access to care initiatives in the state. An evaluation subcommittee was formed to examine first trimester enrollment rates for women served by MCH-funded presumptive eligibility services in local public health departments. The subcommittee piloted a telephone survey to find out if pregnant women with presumptive eligibility determinations qualified for Medicaid and if they found a health care provider. The survey was piloted from April to July 2009 to assess accuracy and validity of the survey questions. During the pilot prenatal care was not uniformly defined and variations and incomplete responses were noted. Therefore, prior to full implementation in 2010, a definition of prenatal care was established, as well as clarification on collecting Medicaid and prenatal care enrollment dates.

The Women's Health Unit initiated a Local Health Agency and Medicaid Workgroup to facilitate communication and improve partnerships between local health agencies and the Department of Health Care Policy and Financing (HCPF). The goal was to improve access to adequate and early care for pregnant women, as well as services to children 19 and younger enrolled in Medicaid. The workgroup met monthly from May 2008 to August 2009. The workgroup was discontinued when it was determined that the goal of the group was being addressed through broader external stakeholder groups such as the Covering Kids and Families Agency Partners

Workgroup, which addresses enrollment issues for pregnant women and children receiving Medicaid or Child Health Plan Plus benefits and the HealthyWomen HealthyBabies Access to Care Workgroup, which addresses system capacity and coordination issues for low-income pregnant women. Additionally, other needs initially identified by the group had been met, including concerns around communication and consistency between Medicaid and local public health agencies.

During 2009, the Healthy Mothers Colorado task force was formed by two non-profit organizations: The Colorado Children's Healthcare Access Program and HealthyWomen, HealthyBabies. The task force was formed to better understand access barriers to timely and comprehensive prenatal care services, as well as barriers to coordinated care before and after delivery for low-income women on public health insurance programs. The task force completed a needs assessment process by conducting key-informant interviews, provider surveys, and reviewing available data for Colorado. The end result was the report, "Comprehensive Prenatal Care Services in Colorado for Low-Income Pregnant Women: Access and Coordination Issues." The report can be found at http://hwhb.org/providers.html. The report contains key recommendations for addressing barriers to access and coordinated care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted a prenatal care assurance telephone pilot survey			X	X
2. Addressed presumptive eligibility determination processes			X	X
3. Participated in a Local Health Agency & Medicaid Workgroup			X	X
4. Participated in the Healthy Mothers Colorado Task Force and the subsequent Healthy Women Healthy Babies Access to Care Workgroup			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 77.0 percent.

The MCH Access to Care Workgroup continues to examine the role of MCH in this area. Based on the results of the pilot survey conducted in early 2009, the MCH Access to Care Subcommittee implemented a revised telephone survey from February to June 2010. The survey targeted pregnant women receiving presumptive determinations at local public health agencies. The survey assessed the efficacy of providing such services in the community. The MCH Access to Care Subcommittee will implement recommendations for additional access to care activities based on the findings of the survey and as a result of the MCH needs assessment.

As a follow-up to the report completed by the Healthy Mothers Colorado Task Force in 2009, an Access to Care Workgroup was formed under the HealthyWomen, HealthyBabies non-profit organization. This workgroup provides a venue for discussion and action on recommendations from the report, to include addressing issues in the following areas: provider availability and access issues; improved access to prenatal care in underserved counties; barriers to ob/gyn physician consultation and referral; and stronger connections and referral relationships between providers of prenatal care, especially private providers, and enhanced service providers and

pediatric providers. The workgroup meets monthly.

c. Plan for the Coming Year
The target for reporting year 2011 is 78.0 percent.

The Women's Health Unit will continue to monitor this measure.

D. State Performance Measures

State Performance Measure 1: *The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11.5	12	12.5	13	7
Annual Indicator	10.9	12.4	22.2	3.5	3.6
Numerator	83139	96907	176643	28096	29808
Denominator	766236	780708	794026	802639	818443
Data Source				Colorado School-Based Health Center Initiative	Colorado School-Based Health Center Initiative
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.2	7.4	7.6	7.8	

Notes - 2009
The annual indicator and numerator for reporting year 2008 reported in the FY10 application were incorrect. The correct annual indicator should have been 3.5 based on a numerator of 28,096. These two items were changed in the FY11 application. The annual performance objectives set in RY08 were based on the incorrect annual indicator and in turn were too high.

Data shown for reporting year 2009 are based on fall 2008 public school enrollment data from the Colorado Department of Education. The numerator includes ONLY students in schools with an ON-SITE school-based health center. A total of 42 schools had an on-site school-based health center in the fall of 2008.

Notes - 2008
Data shown for reporting year 2008 are based on Fall 2007 public school enrollment data from the Colorado Department of Education. The numerator includes ONLY students in schools with an ON-SITE school-based health center. A total of 39 schools had an on-site school-based health center in the fall of 2007.

Notes - 2007

Data shown for reporting year 2007 are based on Fall 2006 school enrollment data. The numerator includes students in schools with school-linked or on-site school-based health centers.

a. Last Year's Accomplishments
The target for reporting year 2009 was 7.0 percent; 3.6 percent was achieved. However, due to a mathematical error in establishing the 7.0 percent target; the appropriate target should have been 3.6 percent. When corrected, the target was met. On-site health services were available to 29,808 out of 818,443 children and adolescents in public schools in Colorado.

During the 2008-09 school year there were 44 school-based health centers. These centers were located in 16 of Colorado's 64 counties. Fifteen programs representing 40 individual centers were supported through the Colorado Department of Public Health and Environment's School-Based Health Center Program. They provided care to 23,635 unduplicated users in over 83,000 visits. Acute illness and injury accounted for 27.0 percent of the visits; health education 24.0 percent and mental health services 21.0 percent.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assisted in the development of Quality Standards for Colorado School-Based Health Centers				X
2. Partnered with the State Medicaid agency on a 5-yr, multi-state quality demonstration grant from the Centers for Medicare and Medicaid Services for a comprehensive evaluation of school-based health centers				X
3. Planned for distribution of State General Fund, private funding and MCH dollars available in next fiscal year				X
4. Issued a Request for Applications for community agencies/school districts to apply for implementation funding			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The corrected target for reporting year 2010 is 3.8 percent.

As of fall 2009, there were 45 school-based health centers in Colorado. Twelve communities throughout the state were engaged in some form of planning activity, either to establish a new school-based health center or to expand to other schools. It is anticipated that up to five new sites will be open by fall 2010. Sixteen programs representing 41 school-based health centers received funding from the Colorado Department of Public Health and Environment's School-Based Health Center Program in the 2009-10 school year. A Request for Applications was posted in March. All sixteen current contractors submitted an application for funding.

Quality Standards for Colorado School-Based Health Centers were developed and approved in late 2009. Concurrently, the School-Based Health Center Program was invited to partner with the state Medicaid agency on a Quality Demonstration Grant application through the Centers for Medicare and Medicaid Services. In partnership with New Mexico, the five-year grant will evaluate the effectiveness of both states' school-based health centers in delivering quality,

comprehensive care to children and youth including those covered by Medicaid and the Children's Health Plan Plus. The intent of the grant is to provide recommendations to the United States Congress on effective programs/approaches that can be replicated on a larger scale.

c. Plan for the Coming Year
The measure will be discontinued.

State Performance Measure 2: *Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	36	31	32	42
Annual Indicator	30.1	30.1	36.0	39.2	42.8
Numerator	117480	103011	121642	128910	157602
Denominator	390299	342229	338186	329020	368291
Data Source				CO Department of Health Care Policy and Financing	CO Department of Health Care Policy and Financing
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	44	46	48	50	

Notes - 2009
Data shown for reporting year 2009 are for fiscal year 2009 for children ages 0 through 18. These data are included in the Form CMS-416 Annual EPDST Participation Report from the Colorado Department of Health Care Policy and Financing.

Notes - 2008
Data shown for reporting year 2008 are for fiscal year 2008 for children ages 0 through 18. This is changed from data in previous reporting years which represented children ages 0 through 20.

Notes - 2007
Data shown for reporting year 2007 are for federal fiscal year 2007.

a. Last Year's Accomplishments
The target for reporting year 2009 was 42.0 percent and 42.8 was achieved. The target was met and exceeded. A total of 157,602 out of 368,291 Medicaid-eligible children received dental services as part of their comprehensive services.

While steady growth continues across all age groups, there have been significant increases within certain age groups. For example, utilization for children age six through nine was 65.0 percent, up 20.0 percent for last year, and children age birth through three has increased 21.0 percent compared to last year. While there is no single reason attributed to the increase in

utilization of oral health services, several factors have had a contributing effect including: building direct capacity; development of strong partnerships and collaborations; participation in statewide access initiatives; and strong advocacy efforts.

The oral health unit worked to build direct capacity for services in this population both through incentives and direct grants. One example of incentive capacity development is the State Dental Loan Repayment Program. The legislative intent of this program was to increase private providers' participation and service to the Medicaid and CHP+ population. The funding process was again very competitive with nearly twice the number of applicants compared to the funds available. The Oral Health Unit leveraged additional federal funds from the Bureau of Health Professions, Grants to States to Support Oral Health Workforce Activities, to expand loan repayment to two additional providers. In total, this effort directly led to almost 30,000 Medicaid-eligible children receiving services from program participants in FY 2009.

Also as part of the same workforce funding, the state contracted directly with mobile providers, such as the University of Colorado, School of Dental Medicine's "Colorado Smilemakers" dental van to provider services in rural and underserved areas. Over 500 clients were seen through August of 2009.

The Oral Health Unit continued to work with its partners to ensure that access to and utilization of Medicaid oral health services remain a priority. Cavity Free at Three (CF3), a statewide multiagency initiative that seeks to improve the oral health of pregnant women and young children, provided grants for technical assistance and implementation to ten communities and demand continues to grow. The Oral Health Unit served as a member of the technical assistance team, and all unit dental professionals were trained in the model, and in turn provided trainings to medical and dental providers. Furthermore as part of this initiative, the Colorado Department of Health Care Policy and Financing has supported amendments to its state plan that allow medical providers access to the two dental codes associated with this program, an oral health assessment and fluoride varnish application.

Reimbursement continues to be a major issue despite an increase in Medicaid reimbursement rates from 47.0 to 52.0 percent of the American Dental Association mean for the Rocky Mountain Region in 2009. Oral Health Awareness Colorado!, the advocate for oral health improvement in the state, worked with various strategic partners including dental safety net providers, the Colorado Dental Association, the Colorado Dental Hygienists Association and community health centers to preserve this increase in provider fees. While some reduction did occur, it was not the 20.0 percent across the board cut other providers faced.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Worked with dental safety-net providers, the Colorado Dental Association, the Colorado Dental Hygienists Association and Oral Health Awareness Colorado! to improve dental access for Medicaid eligible children			X	X
2. Continued the State Dental Loan Repayment program	X	X	X	
3. Participated in the Cavity Free at Three Program	X	X	X	X
4. Participated in the Medical Home Advisory Task Force to assure oral health is integrated, per legislation, into the Medical Home Concept				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 44.0 percent.

Activities previously described continued.

The Oral Health Unit continued to work with Oral Health Awareness Colorado!, a statewide oral health coalition, to restore the provider reimbursement to a full 52.0 percent of the American Dental Association mean for the Rocky Mountain Region.

The Unit worked with the Colorado Department of Health Care Policy and Financing to ensure that Medicaid oral health data are accurate and provided in a timely manner.

The unit worked with the private sector and MCH partners to increase oral health within the early childhood system including enrollment, screening, referral, and access to services.

c. Plan for the Coming Year
The measure will be discontinued. A new measure focused on the prevention of the development of dental caries in all children age birth to five will be added.

Current activities will continue.

The Oral Health Unit will release the early childhood caries systems dynamics model to help develop programs that impact early childhood oral health most significantly such as fluoride applications, community water fluoridation, local capacity building, etc.

The Unit will develop an MCH Action Guide directed at increasing community organization related to oral health initiatives and provide technical assistance through the Early Childhood Initiatives and Health Integration Grants.

State Performance Measure 3: *The percentage of women with inadequate weight gain during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	22.5	22.3	22	20.7	25
Annual Indicator	24.5	18.7	27.5	26.3	25.9
Numerator					
Denominator					
Data Source				Birth certificates	Birth Certificates
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	24	24	

Notes - 2009

Data shown for 2009 are from the 2008 Colorado birth certificate. The results represent ALL singleton births to Colorado residents delivering in Colorado during calendar year 2008. Data shown in reporting year 2008 are from the 2007 Colorado birth certificate data, but represent TERM singleton births. Data shown for reporting years 2007 and earlier are Pregnancy Risk Assessment Monitoring System (PRAMS) survey data for TERM singleton births.

Notes - 2008
Data shown for 2008 are from 2007 Colorado birth certificate data. These represent term, singleton births to Colorado residents delivering in Colorado during calendar year 2007. Data shown for previous reporting years are Pregnancy Risk Assessment Monitoring System (PRAMS) survey data.

Notes - 2007
Data shown for 2007 are from the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS).

a. Last Year's Accomplishments
The target for reporting year 2009 was 25.0 percent, and 25.9 percent was achieved. The target was not met. The annual indicator showed that 25.9 percent of women had inadequate weight gain during pregnancy.

With the release of Tipping the Scales: Weighing in on Solutions to the Low Birth Weight Problem in Colorado in 2000, a long-term effort to reduce the incidence of inadequate weight gain (IWG) during pregnancy was initiated. According to the Tipping the Scales population attributable risk (PAR) analysis, inadequate prenatal weight gain has a significant impact on Colorado's low birth weight rate. The report stated that Colorado's low birth weight rate among singleton births could be reduced by nearly a full percentage point if all women gained the recommended amount of weight during pregnancy. As a result of the study, the Healthy Baby campaign was developed.

The Women's Health Unit continued Healthy Baby campaign activities from the previous year. The campaign included efforts to educate consumers about the importance of appropriate pregnancy weight gain with respect to positive birth outcomes. Prenatal providers were encouraged to use Institute of Medicine (IOM) recommendations for prenatal weight gain when counseling patients.

The Healthy Baby campaign website (www.healthy-baby.org) was redesigned to reflect the broader emphasis of the larger campaign. The website promotes emerging preconception health, gestational diabetes guidelines and postpartum depression resources, including an interactive Edinburgh Postpartum Depression screening tool. Prenatal smoking cessation components were added to complement the appropriate weight gain message. Website content was made available in English and Spanish languages.

The percent of women with inadequate weight gain dropped significantly in 2006 to 18.7 percent, but increased the next year to 27.5 percent. Data analysis determined that the 2006 rate decline was statistically significant. Analysis concluded that the Healthy Baby campaign social marketing activities in ten large counties contributed to the short-term rate decrease in 2006. (Attachment)

A literature review revealed that smoking cessation and nutrition promotion activities are promising practices that best impact reducing low birth weight and promoting preconception health. Key strategies include the use of intensive, individualized nutrition counseling and follow-up throughout pregnancy.

Ten counties incorporated prenatal smoking cessation and appropriate maternal weight gain using the MCH Healthy Baby Action Guide.

Women's Health staff members continued participation on the Healthy Women HealthyBabies

(HWHB) Preconception Care Workgroup. The HWHB Preconception Care Workgroup worked to improve access to preconception care services within the state.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assisted local health departments in including Healthy Baby campaign strategies into their MCH plans	X	X	X	
2. Continued web site activities			X	
3. Participated in the HWHB Preconception Care Workgroup			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 25.0 percent.

The population attributable risk (PAR) analysis was updated to identify major contributors to low weight births in Colorado.

The Healthy Baby campaign website continued to promote preconception health using an expanded life course perspective. Website consumer and provider content are updated on a regular basis. Campaign print materials are available free of charge to providers via an online ordering system.

Women's Health Unit and WIC staffs are working together to revise weight gain grids and Healthy Baby campaign materials to reflect the 2009 IOM prenatal weight gain recommendations. Consumer and provider outreach continued via local and state health agency activities, as well as professional presentations that promote the Healthy Baby campaign. Consultation and technical assistance were provided to ten local health agencies choosing to use Healthy Baby campaign strategies in their MCH plans.

Women's Health Unit staff members continue to participate in the HealthyWomen HealthyBabies (HWHB) Preconception Care Workgroup. The workgroup strives to improve birth outcomes by increasing the availability of preconception counseling.

The Women's Health Unit funded the development of Preconception and Interconception Clinical Practice Guidelines in December 2009.

Women's Health staff began work with content experts to develop a Life Plan tool for women of reproductive age.

c. Plan for the Coming Year
The measure will be discontinued. A new measure on preconception care and early childhood obesity prevention will be included.

The Healthy Baby campaign will continue to promote preconception health using the life course perspective. Campaign materials will be updated to reflect new IOM prenatal weight gain recommendations. Some materials may be discontinued based on low provider utilization. Consumer and provider outreach will continue via local health agency activities. Professional presentations and webinars that promote appropriate maternal weight gain, prenatal smoking cessation and preconception health will be offered to providers. Consultation and technical assistance will be provided to ten local health agencies choosing to use Healthy Baby strategies in their MCH plans.

Women's Health staff will continue to participate in the HWHB Preconception Care Workgroup to improve birth outcomes by increasing the prevalence of preconception counseling among women in Colorado. Preconception health consumer education strategies are being explored.

Work will continue on the Life Plan tool that provides information about financial security, emotional health, healthy relationships, tobacco and alcohol use, family planning, personal safety, immunizations, nutrition, and chronic illness management. Focus groups information and other qualitative evalution will be used to shape the final content. Favorable evaluation results may prompt mass production of a hard-copy Life Plan booklet, a web based version of the Life Plan tool and a social media application. Versions of the Life Plan tool for teens and men are a possible course of action.

State Performance Measure 5: *The motor vehicle death rate for teens 15-19 years old.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28	18	17	16
Annual Indicator	31.2	18.6	19.0	17.0	14.0
Numerator	107	65	67	61	51
Denominator	342486	348573	352852	358249	363012
Data Source				2007 death certificates	2008 death certificates
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	14	13	12.5	

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 data representing deaths from all motor vehicle injuries for teens age 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data representing deaths from all motor vehicle injuries for teens age 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are 2006 calendar year data.

a. Last Year's Accomplishments
The target for reporting year 2009 was 16.0 deaths per 100,000 teens and 14.0 deaths per 100,000 teens was achieved. The target was met. A total of 51 deaths among teens 15 to 19 years old were due to motor vehicle crashes.

The Colorado Teen Driving Alliance (formerly called the Teen Motor Vehicle Leadership Alliance), a statewide coalition composed of state and local public and private partners, met monthly to coordinate the implementation of the Alliance work plan. The Alliance distributed 43,500 brochures in English and Spanish to teens and their parents. New teen driving toolkits were created and posted on the Colorado Teen Driver website (www.coteendriver.com) and distributed quarterly to schools. The Alliance created pocket-sized Colorado Graduated Drivers Licensing (GDL) law "cheat sheets" and distributed 5,000 copies to traffic officers statewide. The Alliance participated in activities that led to legislation prohibiting the use of cell phones while driving for teens and prohibits all drivers from text messaging while driving.

The Injury, Suicide and Violence Prevention (ISVP) Unit hosted a Colorado Child and Adolescent Motor Vehicle Safety Symposium for state and local partners addressing teen motor vehicle safety issues. This one-day symposium brought 140 members of the motor vehicle safety community together to share their successes in reducing road traffic injures and ideas about how to continue to improve the motor vehicle safety of children and adolescents in Colorado. During the Symposium, a representative from the Insurance Institute for Highway Safety presented information about optimal graduated driver's license (GDL) laws and provided and recommended ways that Colorado could strengthen its law.

The Colorado Child Fatality Prevention State Review Team's 2009 Legislative report included recommendations to establish a statutory requirement that allows for primary enforcement of the seat belt law and to increase parental awareness and support enforcement of the Graduated Drivers Licensing Law.

The ISVP Unit updated the Teen Motor Vehicle Action Guide to help Maternal and Child Health (MCH) Programs at local public health agencies develop activities that address motor vehicle safety in their communities. Injury Prevention Program staff provided technical assistance to six local MCH Programs that are currently addressing motor vehicle safety with their MCH funding from the Colorado Department of Public Health and Environment. The MCH Action Guide for this area is at http://www.cdphe.state.co.us/ps/mch/actionguides.html.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participted and maintained the Teen Motor Vehicle Leadership Alliance				X
2. Implemented a social marketing campaign to educate and motivate law enforcement, parents, and youth to follow Colorado's GDL Law			X	
3. Provided technical assistance and consultation to statewide and local community organizations interested in or currently addressing teen motor vehicle safety		X	X	X
4. Developed and distributed educational materials		X	X	X
5. Educated decision makers about the issue of distracted driving				
6. Held a statewide child and adolescent motor vehicle symposium		X	X	
7.				
8.				

9.				
10.				

b. Current Activities
The target for reporting year 2010 is 15.0 deaths per 100,000 teens.

The state health department continued to convene the Teen Driving Alliance. In December 2009, the Alliance updated parent and teen brochures to provide the latest information about the graduated driver's license (GDL) law. The Alliance also held two teen focus groups to get input about what other social marketing materials should be created. Additionally, the Alliance updated the law enforcement GDL cheat sheets.

The Alliance partnered with the Colorado Department of Transportation to create a new local communities section on the Colorado Teen Driver website at www.coteendriver.com to promote evidence-based practices and encourage coordination of teen motor vehicle safety efforts around the state.

The Alliance created a public service announcement contest for teens to help educate the public about the new cell phone law and 150 submissions were received from high school students. Governor Ritter announced the winning PSAs during two press conferences on December 1, 2009, the day the law went into effect.

The Alliance provided information in response to primary seatbelt legislation proposed during the 2010 legislative session.

ISVP Unit staff gave a presentation on integrating injury prevention programs with MCH programs at the Safe States Alliance Annual Meeting.

c. Plan for the Coming Year
The target for reporting year 2011 is 14.0 deaths per 100,000 teens. This state performance measure will not be discontinued, it will be the new State Performance Measure #9. It is likely that the annual performance objectives for the new state performance measure will change in next year's application.

The ISVP Unit received a two-year grant to create a Child Injury Prevention Policy Plan that includes strategies to enhance Colorado's GDL law by: increasing the minimum age for a learner's permit from 15 to 16; increasing the minimum age for an intermediate license from 16 to 17; and expand the restricted hours for intermediate drivers from between midnight and 5 a.m. to between 10 p.m. and 5 a.m. The Child Fatality Prevention System also included this recommendation in its 2010 Annual Legislative Report. The ISVP Unit formed a new Child Injury Policy Subgroup (CIPS) of the existing Injury Community Planning Group to oversee the development, implementation and evaluation of the Policy Plan. In order to develop the Policy Plan, CIPS members conducted a systematic review of existing best practice policy recommendations and GDL laws from other states and completed an analysis of teen driving safety stakeholders. Policy Plan was completed in June 2010 and will be introduced to teen driving safety partners at a statewide Injury, Suicide and Violence Prevention Conference in August 2010.

The state health department will continue to convene the Colorado Teen Driving Alliance.

The Alliance will implement the strategies outlined in the Child Injury Prevention Policy Plan to educate the public about the importance of the GDL law.

The ISVP Unit will continue to provide technical assistance to local MCH programs that are

working on teen driving safety projects.

State Performance Measure 7: *The proportion of all children 2-14 whose BMI is at or above 85% of normal weight for height.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28.6	28.6	27	28
Annual Indicator	28.8	27.5	25.8	28.7	25.2
Numerator					
Denominator					
Data Source				Colorado Child Health Survey	Colorado Child Health Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	27	27	26	

Notes - 2009
Data shown for reporting year 2009 are calendar year 2009 Colorado Child Health Survey results for children ages 2-14.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2008 Colorado Child Health Survey data for children ages 2-14.

Notes - 2007
Data shown for reporting year 2007 are calendar 2007 Colorado Child Health Survey data for children age 2-14.

a. Last Year's Accomplishments
The target for reporting year 2009 was 28.0 percent and 25.2 percent was achieved. The target was met. The annual indicator showed that 25.2 percent of children ages 2-14 had a BMI at or above 85 percent of normal weight for height.

Between October 2008 and September 2009, a collaborative effort between the Child, Adolescent and School Health Unit (CASH), Colorado Physical Activity and Nutrition (COPAN) Program, and the Child and Adult Care Food Program (CACFP) held a series of meetings to determine how to best leverage resources across programs to collaboratively impact early childhood obesity. As a first step, the partners agreed to jointly-fund a review of the literature to identify evidence based strategies and best practices for early childhood obesity prevention. The group also partnered with the Metropolitan State College in Denver to perform an environmental scan of early childhood obesity prevention practices, attitudes, and needs of child care providers in Colorado. Some of the findings from this work were presented in a poster format at the Colorado Public Health Association conference in September 2009 to encourage a local public health focus on this priority.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Created a scope of work for early childhood obesity prevention project and hired temporary staff				X
2. Completed a literature review and recommendations on early childhood obesity prevention				X
3. Presented a poster on early childhood obesity prevention at the Colorado Public Health Association conference		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 28.0 percent.

A review of the early childhood obesity prevention literature was completed in March 2010. Through this research, the Early Childhood Obesity Collaborative found that the greatest evidence base for preventing early childhood obesity exists within the preconception, prenatal, and birth through two years periods of life. The CASH Unit and the Women's Health Unit's Prenatal Program are working together to determine next steps in implementing the identified promising strategies. In May, the Early Childhood Obesity Prevention Collaborative drafted a timeline for a statewide strategic planning process that will begin in October 2010.

In April, members from the Early Childhood Obesity Collaborative presented their findings at the Prenatal Plus Statewide Conference and will also be presented at the American Public Health Association National Conference in November 2010.

c. Plan for the Coming Year
The measure will be discontinued. A new measure will address early childhood obesity prevention from birth to age 5.

State Performance Measure 8: *Percent of children who have difficulty with emotions, concentration, or behavior.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		28	28	27	24
Annual Indicator	29.2	25.3	28.2	24.2	24.2
Numerator					
Denominator					
Data Source				Colorado Child Health Survey	Colorado Child Health Survey
Is the Data Provisional or				Final	Final

Final?					
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24	23	23	22	

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008 Colorado Child Health Survey results for children ages 1-14. This particular question was not included on the 2009 Child Health Survey questionnaire so 2009 results are not available.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2008 Colorado Child Health survey data for children age 1-14.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2007 Colorado Child Health survey data for children age 1-14.

a. Last Year's Accomplishments
The target for reporting year 2009 was 24.0 percent and 24.2 percent was achieved. The target was not met. The annual indicator showed that 24.2 percent of children had difficulty with emotions, concentration, or behavior.

CASH Unit staff and state early childhood mental health experts discussed how to refine this measure.

As of September 2009, the CASH Unit has represented Maternal Child Health on the Pyramid Plus State Policy Team. This team was charged with providing state level support for the Pyramid Model for Social Emotional Development and the Special Quest approach to inclusion. The model was developed by the Center on the Social and Emotional Foundations for Early Learning and addresses the social emotional development and school readiness of young children birth to age 5.

The CASH Unit participated in work groups and other efforts to address early childhood mental health with partners such as local public health agencies, early childhood councils and statewide mental health consultants.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in work groups and other efforts with various partners such as local public health agencies, early childhood councils and statewide mental health consultants			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The target for reporting year 2010 is 24.0 percent.

The Child, Adolescent and School Health (CASH) Unit worked with partners including local public health agencies, early childhood councils and statewide mental health consultants to promote early identification and intervention for children with challenging behaviors.

In April, the CASH Unit participated in a cross agency effort to develop a tool to assist communities with gap identification and subsequent decision-making in choosing social emotional programming for early care and education providers.

In May, the CASH Unit participated in a multi-agency discussion, hosted by the Colorado Association for Infant Mental Health, regarding the feasibility of an Early Childhood Mental Health Endorsement. The endorsement is a replication of an initiative from Michigan, focused on reflective supervision and training for mental health professionals in early childhood.

Through the Early Childhood Health Integration Initiative, three early childhood councils in Colorado address a social emotional outcome as a focus for their early childhood systems building work in their regions. The CASH Unit hosted a webinar on the Pyramid Model for the early childhood councils.

Several councils have also chosen to implement a medical home approach in their communities, which will involve local mental health services and programs.

Through an MCH contract with Qualistar mental health resources are provided to a network of child care health consultants.

c. Plan for the Coming Year
The measure will be discontinued.

State Performance Measure 9: *Percent of center-based child care programs using a child care nurse consultant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		90	92	94	96
Annual Indicator		88.6	90.0	95.8	96.7
Numerator		1528	1709	1104	1160
Denominator		1724	1898	1153	1200
Data Source				Qualistar Early Learning	Qualistar Early Learning
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	

Notes - 2009
Data shown for reporting year 2009 are from the Qualistar Early Learning Survey conducted in the spring of 2010. These data are limited to child care centers, while data reported in reporting years 2007 and earlier included preschools as well as child care centers.

Notes - 2008
Data shown for reporting year 2008 are from the Qualistar Early Learning Survey conducted in the spring of 2009. These data are limited to child care centers, while data reported in earlier reporting years included preschools as well as child care centers.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2007 data.

a. Last Year's Accomplishments
The target for reporting year 2009 was 96.0 percent and 96.7 percent was achieved. The measure was met. A total of 1,160 out of 1,200 center-based child care programs used a health consultant.

The Child Health Liaison (CHL) program was successfully expanded into Pueblo, El Paso and Summit counties, so there are now four CHL communities. The process to start a new CHL program has been documented and shared with local public health agencies that are planning to start their own program.

To support the work of child care health consultants, a Medication Administration DVD was developed to serve as a companion resource to the recently revised Child Care Provider's Medication Administration manual. The intent of the DVD is to train the non-professional individuals who are responsible for the administration of medication to infants, toddlers, preschool and school-aged children in all types of out-of-home child care, schools and camp settings. The DVD development was a collaborative effort with Healthy Child Care Colorado (HCCC), Colorado Department of Education, and the CASH Unit.

The HCCC Director provided 23 educational sessions and distributed 433 DVDs statewide. In the fall of 2009, the DVD was highlighted at the American School Health Association conference.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded the Child Health Liaison program into three new counties		X	X	
2. Developed a medication administration DVD as a companion resource to the recently revised Child Care Provider's Medication Administration manual		X	X	
3. Distributed 433 DVDs at 23 education sessions for child care professionals		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 98.0 percent.

Data collected about the use of child care health consultants through a statewide survey of child care providers, administered by Qualistar Early Learning, will be included in Colorado's MCH Datasets. Also, county specific information will be made available to child care programs upon

request.

The MCH program maintained a contract with Qualistar Early Learning to support Healthy Child Care Colorado through June 2010. The Child, Adolescent, and School Health (CASH) Unit is currently participating in brainstorming next steps for Healthy Child Care Colorado and assisting with the identification of future funding opportunities.

Through the Healthy Child Care Colorado contract, technical assistance was provided to local public health agencies offering the Child Health Liaison program.

c. Plan for the Coming Year
The measure will be discontinued.

State Performance Measure 10: *The proportion of high school students reporting binge drinking in the past month.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	29	29	29
Annual Indicator	30.6	30.6	30.6	31.8	25.1
Numerator					
Denominator					
Data Source				2007 High School YRBS	2009 High School YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29	29	28	28	

Notes - 2009
Data shown for reporting year 2009 are 2009 Colorado Youth Risk Behavior Survey results.

Notes - 2008
Data shown for reporting year 2008 are fall 2007 Colorado Youth Risk Behavior Survey results. Note that the 2007 YRBS results were not weighted to represent all high school students in the state.

Notes - 2007
Data shown are Fall 2005 Colorado Youth Risk Behavior Survey results first reported in 2005. No newer data are available. The YRBS Survey was conducted in the Fall of 2007, but results were not available at the time these data were submitted.

a. Last Year's Accomplishments
The target for reporting year 2009 was 29.0 percent and 25.1 percent was achieved. The target was met. The annual indicator showed that 25.1 percent of high school students reported binge drinking in the past month.

The Colorado Prevention Partners completed the grant objectives for the fifth and final year of funding of a Strategic Prevention Framework grant from the Substance Abuse and Mental Health Services Administration. These objectives focused on sustaining local coalitions and sharing lessons learned in addressing underage alcohol use. Sixteen communities participated in the Strategic Prevention Framework process.

The Colorado Department of Human Services, Division of Behavioral Health, led the Prevention of Alcohol Related Consequences (PARC) Committee (formerly called the Underage Drinking Prevention and Reduction Workgroup). The PARC Committee is responsible for prevention and reduction of underage drinking statewide while increasing intervention and treatment services to all youth, when needed. The Committee supported law enforcement in carrying out Colorado's statutes regarding adults furnishing alcoholic beverages to youth through community-based education. Law enforcement officers, district attorneys and judges were encouraged to pursue the source of the alcohol when minors were cited for possession, consumption or related offenses. They also supported the development of a DUI education and treatment curriculum for youth age 20 and under, which is a supplement to the Driving with Care curriculum. The Department of Behavioral Health held several trainings for eligible treatment providers to use the curriculum.

The PARC workgroup developed strategies to educate youth and parents about statutes affecting young driver's driving privileges; supporting law or liquor enforcement personnel in conducting alcohol compliance checks; educating retail outlet staff on the importance of responsible alcohol sales practices; and providing support to communities about evidence-based programs, policies and practices identified by community-based Underage Drinking Prevention Coalitions. Five evidence-based programs to prevent underage drinking were identified including: TIPS, a bartender education and training program; Project Northland, a school-based prevention program; Protecting You Protecting Me, an alcohol use prevention curriculum for grades one through five; and Reconnecting Youth, a semester-long class for at risk youth. A logic model that documents underage drinking and its relationship to alcohol-related crashes was developed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued participating in the Colorado Prevention Partners group to influence teen binge drinking				X
2. Provided technical assistance to Colorado community coalitions addressing underage drinking prevention		X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2010 is 29.0 percent.

Activities described in the previous year will continue until the measure is discontinued this year.

c. Plan for the Coming Year
The measure will be discontinued.

E. Health Status Indicators

Introduction
Brief narratives are shown below regarding each of the Health Status Indicators.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9.0	9.3	9.0	9.0	8.9
Numerator	6172	6379	6377	6397	6263
Denominator	68475	68922	70737	70804	70028
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for 2009 are calendar year 2008.

Notes - 2008
Data shown for 2008 are calendar year 2007.

Notes - 2007
Data shown for 2007 are calendar year 2006 data.

Narrative:
The low birth weight rate declined from 9.0 percent to 8.9 percent in reporting year 2009, the lowest rate since reporting year 2003 when it was also 8.9. It appears that the decline in the rate may be due to a drop in the number of multiple births which have a high rate of low birth weight.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.2	7.3	7.2	7.1	7.1
Numerator	4784	4885	4913	4874	4826
Denominator	66259	66610	68475	68426	67812
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008.

Notes - 2008

Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for 2007 are calendar year 2006 data.

Narrative:
The singleton low birth weight rate for reporting year 2009 was 7.1, the same as for the previous year.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.3	1.3	1.3	1.3	1.3
Numerator	889	902	889	930	928
Denominator	68475	68922	70737	70804	70028
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Narrative:
The state very low birth weight rate has not changed in the past several years and remains at 1.3 percent in reporting year 2009.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.0	1.0	0.9	1.0	1.0
Numerator	657	682	639	688	678
Denominator	66259	66610	68475	68426	67812
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for 2007 are calendar year 2006 data.

Narrative:
The singleton very low birth weight rate for reporting year 2009 was 1.0, the same as for the previous year.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.1	6.7	6.3	5.4	6.5
Numerator	59	66	63	55	67
Denominator	970051	989454	1002764	1019648	1036835
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Narrative:
The child death rate due to unintentional injuries rose from 5.4 in reporting year 2008 to 6.5 in reporting year 2009. This rate is higher than the previous two reporting years, but still below the rate of 6.7 in reporting year 2006.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.4	3.2	3.2	2.7	2.6

Numerator	33	32	32	28	27
Denominator	970051	989454	1002764	1019648	1036835
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008. Data were obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007. Data were obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Narrative:
The child death rate due to motor vehicle crashes in reporting year 2009 was 2.6, the lowest rate of the last five reporting years shown.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	27.1	24.4	18.7	18.2	16.4
Numerator	182	170	134	134	123
Denominator	671687	696111	717085	736038	748317
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for reporting year 2009 are calendar year 2008. Data were obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007. Data were obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Narrative:
The death rate for youth due to motor vehicle crashes has been declining in the last five reporting years. The rate in reporting year 2009 was 16.4 per 100,000, the lowest rate since it was first included in this grant in reporting year 1998.

Changes in Graduated Driver Licensing laws (instituted in 1999) are being credited with much of the decline. In 2005, Colorado strengthened the laws to limit passengers riding with inexperienced drivers, to prohibit learners' permit holders to use cell phones while driving, and to require seatbelts for all occupants under age 18. A new driver under age 18 cannot have any passengers under age 21 until the driver has held a driver's license for at least six months. In addition, a new driver under age 18 cannot have more than one passenger under age 32 until the driver has had his license for at least one year.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	184.0	170.7	160.9	162.2	172.4
Numerator	1785	1689	1613	1654	1787
Denominator	970051	989454	1002764	1019648	1036835
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for 2009 are calendar year 2008 from the Colorado Hospital Association discharge data set. Data represent nonfatal injuries to Colorado residents aged 0 through 14. The denominator represents the 2008 population ages 0 through 14 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2008
Data shown for 2008 are calendar year 2007 from the Colorado Hospital Association discharge data set. Data represent nonfatal injuries to Colorado residents aged 0 through 14. The denominator represents the 2007 population ages 0 through 14 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. The numerator is the number of injury hospitalizations among children aged 14 and younger minus the injuries that resulted in death (nonfatal).

Narrative:
The rate of non-fatal injuries for children 14 and younger increased for the second year in a row, to 172.4 in reporting year 2009, the highest since reporting year 2005.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	32.2	28.9	24.8	22.5	23.2
Numerator	312	286	249	229	241
Denominator	970051	989454	1002764	1019648	1036835
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for 2009 are calendar year 2008 from the Colorado Hospital Association discharge data set. Data represent nonfatal injuries to Colorado residents aged 0 through 14. The denominator represents the 2008 population ages 0 through 14 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2008
Data shown for 2008 are calendar year 2007 from the Colorado Hospital Association discharge data set. Data represent nonfatal injuries to Colorado residents aged 0 through 14. The denominator represents the 2007 population ages 0 through 14 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. The numerator is the number of injury hospitalizations among children aged 14 and younger minus the injuries that resulted in death (nonfatal).

Narrative:
The rate of non-fatal injuries due to motor vehicle crashes for children 14 and younger increased slightly to 23.2 in reporting year 2009. This is the first increase after four years of decreases.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	170.2	153.6	144.6	140.6	130.6
Numerator	1143	1069	1037	1035	977
Denominator	671687	696111	717086	736038	748317
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data shown for 2009 are calendar year 2008 from the Colorado Hospital Association discharge data set. Data represent nonfatal injuries to Colorado residents aged 15 through 24. The denominator represents the 2008 population ages 15 through 24 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2008
Data shown for 2008 are calendar year 2007 from the Colorado Hospital Association discharge data set. Data represents nonfatal injuries to Colorado residents aged 15 through 24. The denominator represents the 2007 population ages 15 through 24 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. The numerator is the number of injury hospitalizations among youth aged 15 through 24 years minus the injuries that resulted in death (nonfatal).

Narrative:
The injury hospitalization rate declined for the fifth consecutive year in reporting year 2009 to 130.6. Since the first year this rate was reported in this grant, the rate has declined 34 percent, from 196.8 per 100,000 in reporting year 1998.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	22.3	23.1	25.6	25.4	34.7
Numerator	3698	3916	4452	4437	6103
Denominator	165861	169243	174069	174660	176095
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for reporting year 2009 are from the CDPHE NETTS data transfer to CDC and are final for 2008. Population estimates for 2008 are from the Colorado State Demography Office.

An increase in screening and improved capacity for data entry may have increased reported cases for reporting year 2009 compared to previous years.

Notes - 2008
Data for reporting year 2008 are from the CDPHE NETTS data transfer to CDC and are final for 2007. Population estimates for 2007 are from the Colorado State Demography Office 2007 population forecasts.

Notes - 2007

STD data for 2007 are from the Active STD*MIS database, based on report date and are provisional. Population estimates for 2007 are from the Colorado Demographer's Office 2007 population forecasts.

Narrative:
The chlamydia rate in reporting year 2009 jumped 37 percent to 34.7 per 1,000. Capacity and system changes within the Colorado STI registry appear to have resulted in cases prior to 2009 being reported in 2009, thus inflating the rate for the year.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.8	9.3	9.3	9.3	14.6
Numerator	6500	7756	7958	7948	12542
Denominator	831151	838121	853985	855855	861987
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for reporting year 2009 are from the CDPHE NETTS data transfer to CDC and are final for 2008. Population estimates for 2008 are from the Colorado State Demography Office.

An increase in screening and improved capacity for data entry may have increased reported cases for reporting year 2009 compared to previous years.

Notes - 2008
Data for reporting year 2008 are from the CDPHE NETTS data transfer to CDC and are final for 2007. Population estimates for 2007 are from the Colorado State Demography Office 2007 population forecasts.

Notes - 2007
STD data for 2007 are from the Active STD*MIS database, based on report date and are provisional. Population estimates for 2007 are from the Colorado Demographer's Office 2007 population forecasts.

Narrative:
The chlamydia rate in reporting year 2009 jumped 57 percent to 14.6 per 1,000. Capacity and system changes within the Colorado STI registry appear to have resulted in cases prior to 2009 being reported in 2009, thus inflating the rate for the year.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	71068	63587	3855	1457	2169	0	0	0
Children 1 through 4	287020	257747	14769	5711	8793	0	0	0
Children 5 through 9	352384	314888	19246	6396	11854	0	0	0
Children 10 through 14	326363	291036	18958	6150	10219	0	0	0
Children 15 through 19	363012	327401	18917	6484	10210	0	0	0
Children 20 through 24	385305	350178	17304	6593	11230	0	0	0
Children 0 through 24	1785152	1604837	93049	32791	54475	0	0	0

Notes - 2011

Narrative:
Colorado has a population of nearly 1.8 million under the age of 25. It is predominately White (includes Hispanic ethnicity) with small minority groups.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	47473	23595	0
Children 1 through 4	191729	95291	0
Children 5 through 9	247726	104658	0
Children 10 through 14	236613	89750	0
Children 15 through 19	275526	87486	0
Children 20 through 24	300923	84382	0
Children 0 through 24	1299990	485162	0

Notes - 2011

Narrative:
Colorado's population has a large Hispanic representation. Over one-quarter of the population under the age of 25 is Hispanic.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live	**Total All**	**White**	**Black or African**	**American Indian or**	**Asian**	**Native Hawaiian**	**More than one**	**Other and Unknown**

births	**Races**		**American**	**Native Alaskan**		**or Other Pacific Islander**	**race reported**	
Women < 15	79	67	4	4	0	0	0	4
Women 15 through 17	2142	1728	160	43	13	0	0	198
Women 18 through 19	4427	3600	351	78	63	0	0	335
Women 20 through 34	52305	45157	2471	492	1789	0	0	2396
Women 35 or older	11060	9681	395	73	540	0	0	371
Women of all ages	70013	60233	3381	690	2405	0	0	3304

Notes - 2011
Total live births for all races may not add up to total deliveries in state Form 8 (70,028) because the age of the mother was unknown for some of the live births.

Narrative:
The vast majority of births are classified as White (includes Hispanic ethnicity) and occur to women between the ages of 20 and 34.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	17	62	0
Women 15 through 17	755	1365	0
Women 18 through 19	2108	2293	0
Women 20 through 34	35818	16139	0
Women 35 or older	8713	2275	0
Women of all ages	47411	22134	0

Notes - 2011

Narrative:
A total of 32 percent of births are Hispanic. Hispanic births outnumber non-Hispanic births for women below age 20, while the reverse is true for older women.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY	**Total**	**White**	**Black or African**	**American Indian or**	**Asian**	**Native Hawaiian**	**More than one race**	**Other and Unknown**

Total deaths	**All Races**		**American**	**Native Alaskan**		**or Other Pacific Islander**	**reported**	
Infants 0 to 1	434	363	51	5	15	0	0	0
Children 1 through 4	71	57	7	0	7	0	0	0
Children 5 through 9	43	36	4	0	3	0	0	0
Children 10 through 14	55	55	0	0	0	0	0	0
Children 15 through 19	190	177	13	0	0	0	0	0
Children 20 through 24	304	279	16	4	5	0	0	0
Children 0 through 24	1097	967	91	9	30	0	0	0

Notes - 2011
Data for reporting year 2009 are calendar year 2008. Data are suppressed for a few age categories under the Asian and other/unknown categories so total children ages 0 through 24 for all races may be a bit lower than the total children ages 0 through 24 for all ethnicities.

Narrative:
There were just under 1,100 deaths in the population below age 25. The largest number of deaths was for infants.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	259	175	0
Children 1 through 4	51	21	0
Children 5 through 9	26	18	0
Children 10 through 14	41	15	0
Children 15 through 19	144	50	0
Children 20 through 24	241	65	0
Children 0 through 24	762	344	0

Notes - 2011

Narrative:
About one-third of deaths under the age of 25 were among Hispanics.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1399847	1254659	75745	26198	43245	0	0	0	2009
Percent in household headed by single parent	24.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percent in TANF (Grant) families	1.4	0.4	2.4	0.9	0.5	0.0	0.0	0.0	2009
Number enrolled in Medicaid	443446	105394	33093	4944	5493	3591	0	290931	2009
Number enrolled in SCHIP	100494	31331	5192	1340	1837	578	0	60216	2009
Number living in foster home care	18033	0	0	0	0	0	0	18033	2009
Number enrolled in food stamp program	180771	0	0	0	0	0	0	180771	2009
Number enrolled in WIC	84129	36754	5699	33246	1167	159	7046	58	2009
Rate (per 100,000) of juvenile crime arrests	3735.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	5.0	3.2	6.8	9.2	2.9	0.0	0.0	0.0	2009

Notes - 2011
Data for reporting year 2009 are calendar year 2008 from the Colorado State Demographer's office.

Data for reporting year 2009 are from the 2008 American Community Survey 1-year estimates, table B09002 "own children under 18 years by family type and age." Race and ethnicity are not available.

Data for reporting year 2009 represent the monthly caseload for September 2009. Data are available from http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/monthly/2009_09_tan.htm#. Source: US Department of Health and Human Services Administration for Children and Families. Racial and ethnic breakdowns are from the Colorado Department of Health Care Policy and Financing.

Data for reporting year 2009 represent state fiscal year 2009. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2009 represent state fiscal year 2009. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2009 represent calendar year 2009. The data are provisional and represent ages 0-20.

Data for reporting year 2009 represent WIC infants and children ages 0-5 who were vouchered WIC participants in February 2010.

Data for reporting year 2009 are calendar year 2008 obtained from the Colorado Bureau of Investigation. http://cbi.state.co.us/dr/cic2k7/state%20totals/statewide_juvenile_arrests.html. Population data for ages 0-17 for the denominator were from the Colorado State Demographer's office.

Data for reporting year 2009 represent the 2008-2009 school year. Data include alternative high schools. Data are available from the Colorado Department of Education.

Data for reporting year 2009 were obtained from the Colorado Department of Health Care Policy and Financing Premiums, Expenditures and Caseload June 2009 Report at www.colorado.gov/cs/satellite/HCPF/HCPF/1209635766663.

Narrative:
Nearly one-quarter of children in Colorado live in a household headed by a single parent. Only about one and a half percent of children are in TANF families and one percent of children are living in foster home care. Almost one in three children in Colorado are enrolled in Medicaid; about one in fourteen children are enrolled in the Colorado Child Health Plan Plus program (CHP+).

In a given month, about one in eight children participate in the food stamp program. Children are only eligible for WIC until age 5; about 23 percent of children age 0-4 were enrolled in WIC.

Child race data are not available for the percent in household headed by a single parent, number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

The percentage of high school drop-outs is highest among American Indian/Native Alaskan and Black adolescents.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	999067	400780	0	2009
Percent in household headed by single parent	0.0	0.0	24.5	2009
Percent in TANF (Grant) families	0.8	2.3	0.0	2009
Number enrolled in Medicaid	152515	183232	107699	2009

Number enrolled in SCHIP	40278	41490	18726	2009
Number living in foster home care	0	0	18033	2009
Number enrolled in food stamp program	0	0	180771	2009
Number enrolled in WIC	33711	50360	58	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3735.0	2009
Percentage of high school drop-outs (grade 9 through 12)	3.6	8.8	0.0	2009

Notes - 2011
The total number of children shown as "Total NOT Hispanic or Latino" and "Total Hispanic or Latino" were determined using proportions derived from American Community Survey 1-year estimates for 2008 applied to Colorado Dept. of Public Health and Environment Health Statistics Section total population estimates by age.

Data for reporting year 2009 are from the 2008 American Community Survey 1-year estimates, table B09002 "own children under 18 years by family type and age." Race and ethnicity are not available.

Data for reporting year 2009 represent the monthly caseload for September 2009. Data are available from http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/monthly/2009_09_tan.htm#. Source: US Department of Health and Human Services Administration for Children and Families. Racial and ethnic breakdowns are from the Colorado Department of Health Care Policy and Financing.

Data for reporting year 2009 represent state fiscal year 2009. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2009 represent state fiscal year 2009. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2009 represent calendar year 2009. The data are provisional and represent ages 0-20.

Data for reporting year 2009 represent WIC infants and children ages 0-5 who were vouchered WIC participants in February 2010.

Data for reporting year 2009 are calendar year 2008 obtained from the Colorado Bureau of Investigation. http://cbi.state.co.us/dr/cic2k7/state%20totals/statewide_juvenile_arrests.html. Population data for ages 0-17 for the denominator were from the Colorado State Demographer's office.

Data for reporting year 2009 represent the 2008-2009 school year. Data include alternative high schools. Data are available from the Colorado Department of Education.

Data for reporting year 2009 were obtained from the Colorado Department of Health Care Policy and Financing Premiums, Expenditures and Caseload June 2009 Report at www.colorado.gov/cs/satellite/HCPF/HCPF/1209635766663.

Narrative:
A higher percentage of Hispanic children (compared to non-Hispanic children) in Colorado live in TANF families.

A higher number of Hispanic than non-Hispanic children in Colorado are enrolled in Medicaid, but

ethnicity was not reported for more than 107,000 children. The number of children enrolled in the Colorado Child Health Plan Plus (CHP+) is about equal between Hispanics and non-Hispanics. Ethnicity was not reported for nearly 19,000 children.

Children are only eligible for WIC until age 5. A higher number of Hispanic than non-Hispanic children age 0-4 were enrolled in WIC.

The percentage of high school drop-outs is higher among Hispanic youth than among non-Hispanic youth.

Child ethnicity data are not available for the percent in household headed by single parent, number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1035768
Living in urban areas	1152389
Living in rural areas	72279
Living in frontier areas	34547
Total - all children 0 through 19	1259215

Notes - 2011
Data are from the 2000 Census; no updates are available.

Narrative:
Most Colorado children live in urban/metropolitan areas. A total of six percent of children live in rural areas and three percent live in counties with fewer than six persons per square mile.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4835406.0
Percent Below: 50% of poverty	4.7
100% of poverty	11.4
200% of poverty	27.6

Notes - 2011
Data are from the Census Bureau's American Fact Finder American Community Survey 2008, C17024, age by ratio of income to poverty level in the past 12 months.

Narrative:
One out of every four Colorado residents lives at or below 200% of the federal poverty level; one of every nine lives at or below 100% percent of the federal poverty level; and one out of every twenty-one lives below 50% percent of the federal poverty level.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1399847.0
Percent Below: 50% of poverty	5.5
100% of poverty	15.1
200% of poverty	34.7

Notes - 2011
Data are 2008 population data from the Colorado State Demographer's office. Data represent children ages 0 through 19.

Data are from the Census Bureau's American Fact Finder American Community Survey 2008, C17024, age by ratio of income to poverty level in the past 12 months. Data represent children under age 18.

Narrative:
One out of every three Colorado children lives at or below 200% of the federal poverty level; one of every six lives at or below 100% percent of the federal poverty level; and just under one in eighteen lives below 50% percent of the federal poverty level.

F. Other Program Activities

The majority of MCH Block Grant supported programs have been addressed within the report, below are two programs not previously discussed in the measures.

The Family Healthline
The Family Healthline is an information referral helpline sponsored by the MCH Program and managed by the contractor Maximus. The Healthline assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, mental health, or parenting support groups. The Healthline specialists speak fluent Spanish and English, and arrangements are made for assisting the hearing-impaired and callers who speak other languages.

The phone line received 10,969 calls from October 2008 to September 2009, approximately 500 more calls than the previous year. The Family Healthline specialists make referrals, usually within each caller's own community. The Healthline's referral network covers many categories: low-cost or free medical care, dental health services, domestic violence counseling, and other basic subsistence resources.

Fourteen percent of the calls were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the proportion of calls not answered) of 6.13 percent, far less that the standard of 10 percent. The majority of the referrals requests are for WIC office information, with most calls for services benefitting individuals under age 25. Ninety-five percent of callers speak English with 43 percent indicating that they do not have health insurance.

Assuring Better Child Health and Development Project (ABCD)
The CASH and HCP Units are working to implement the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns. The project is supported by the MCH Block Grant and funds from Colorado-based private foundations. The program manager and a trainer for the project is housed at the Arapahoe County Early Childhood Education Council and personnel are working with 25 counties to increase the use of developmental screenings.

G. Technical Assistance

Colorado's technical assistance need is shown on Form 15. The program is seeking assistance in evaluating systems building initiatives.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	7230230	7249480	7249480		7249480	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	4736061	4736061	4736061		4736061	
4. Local MCH Funds *(Line4, Form 2)*	686612	701049	701049		701049	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	12652903	12686590	12686590		12686590	
8. Other Federal Funds *(Line10, Form 2)*	92573760	121013718	113762658		121013718	
9. Total *(Line11, Form 2)*	105226663	133700308	126449248		133700308	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2749412	2500952	2570888		2661982	
b. Infants < 1 year old	0	0	0		0	

c. Children 1 to 22 years old	3479274	3688096	3491508		3494280	
d. Children with Special Healthcare Needs	5454625	5708143	5940930		5830436	
e. Others	0	0	0		0	
f. Administration	969592	789399	683264		699892	
g. SUBTOTAL	12652903	12686590	12686590		12686590	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		99883		94160	
c. CISS	142700		144729		127058	
d. Abstinence Education	0		3651		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	85900000		107930505		115191075	
h. AIDS	0		0		0	
i. CDC	1567964		1104400		1203569	
j. Education	0		0		0	
k. Other						
CBCAP	1074900		753788		776422	
CSHCN	0		0		609036	
Suicide Prevention	515714		489939		372305	
Title X	3167153		3235763		2640093	
Preventive Block Gra	105329		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	476492	488267	330000		450000	
II. Enabling Services	3501806	2782806	3220090		2755000	
III. Population-Based Services	3775665	3776627	3650000		3700000	
IV. Infrastructure Building Services	4898940	5638890	5486500		5781590	
V. Federal-State Title V Block Grant Partnership Total	12652903	12686590	12686590		12686590	

A. Expenditures

Information on annual expenditures is contained in Form 3, Form 4, and Form 5.

2009 expenditures were allocated 9.37% to Administration; 33.17% to Children with Special

Health Care Needs; 35.09% to Child and Adolescent and 22.38% to Maternal and Infant Services.

Form 3
Line 1 - Federal Allocation -- The Federal allocation award in FY 2009 was slightly higher than budgeted for the year by $19,250 ($7,249,480 vs. $7,230,230).

Line 4 -- Local MCH Funds - The Federal Allocation was $19,250 higher ($7,249,480 vs. $7,230,230), therefore, anticipated 75% match requirement was higher. The difference between budgeted and expended is $14,437 ($701,049 vs. $686,612) which comes from Local MCH funds.

Line 8 - Other Federal Funds - The large variation between budgeted and expended ($85,900,000 vs. $115,191,075) is due to under estimation of the Women, Infants & Children (WIC) and the Child & Adult Care Food Program (CACFP) funding. The WIC Program funds substantially increased by $29,291,075. The original estimate was underestimated 2 years ago.

Form 4
Line 1. a. - Pregnant Women - Budgeted vs. expended did not substantially vary.

Line 1. c. - Children age 1 to 22 - Budgeted vs. expended did not substantially vary.

Line 1. d. Children with special health care needs - Budgeted vs. expended did not substantially vary.

Line 1. f. Administration -- The need for administrative dollars from State match sources (General and Cash fund) was about $135,099 less than projected in the original budget.

Form 5
Line I - Direct Health Care Services - Budgeted vs. expended did not substantially vary.

Line II - Enabling Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on enabling services in order to increase effort at the population-based and infrastructure building levels. The state feels that a great proportion of the total MCH population is served with this approach.

Line III -- Population-Based Services -- Budgeted vs. expended did not substantially vary.

Line IV -- Infrastructure Building Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on direct health care and enabling services in order to increase effort at the population-based and infrastructure building levels. The state feels that a great proportion of the total MCH population is served with this approach.

B. Budget

Budget information is contained in Forms 2, 4, 5, and 10.

Form 2
Line 1 - Federal allocation - is shown at $7,249,480 for 2011. Of these dollars, a total of 33.35% ($2,417,585) will be allocated for preventive and primary care for children; 32.83% ($2,380,140) for children with special health care needs, and 9.65% ($699,892) will be spent on administration. These proportions meet the MCH Block Grant requirements.

Line 3 - State MCH Funds - show state funds of $4,736,061 and local funds of $701,049 meeting

the requirement that the total amount of $5,437,110 equals three-fourths of the federal allocation. The state maintenance of effort from 1989 is $4,736,061. The total state match for FY 11 is $4,736,061, which is the same amount.

Line 7 - Total state match - consists of state general funds in the amount of $3,162,000 and cash funds in the amount of $1,574,061(genetics counseling fees). Local funds that support prenatal and child health activities conducted at local health departments total $701,049.

Line 9. c. - Other Federal Funds - the CISS grant line is the State Early Childhood Comprehensive System Grant.

Line 9. g. - Other Federal Funds - WIC - funds include $91,950,098 for Women, Infants & Children; $23,065,494 Child & Adult Care Food Program; $175,483 for WIC Peer Counseling.

Line 9. i. - Other Federal Funds - Centers for Disease Control - funds include $585,726 for Injury Prevention; $14,822 for Injury Surveillance; $566,745 for Sexual Violence Prevention; $36,277 for Building Comprehensive Prevention Program Planning Evaluation Capacity project; .

Line 9. k. - Other Federal Funds - Other Funds include $776,422 for Community-Based Child Abuse Programs from the Administration for Children and Families, Office of Child Abuse and Neglect; $372,305 Suicide Prevention: Project Safety Net; $2,640,093 Title X funds; and $609,036 for Children with Special Health Care Needs (Early Hearing Detection, Integrated Community Systems, Universal Newborn Screening).

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.